Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

Centers for Medicare and Medicaid Services (CMS)

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

Transmittal 6 **Date: September 2014**

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After June 30, 2014.

This transmittal updates Chapter 40, Hospital and Hospital Health Care Complex Cost Report, (Form CMS-2552-10) to clarify and correct the existing instructions and incorporate statutory and regulatory changes. Effective dates will vary.

Revisions include:

- Worksheet S-2, Part I: Clarified instructions for uncompensated care, Medicaid days, and transplant center information.
- Worksheet S-3, Part I: Opened column 14, line 2 and added instructions for reporting Medicaid managed care discharges.
- Worksheet S-3, Part II: Clarified instructions relating to the wage index and revised the forms relating to contract labor on lines 11 and 12.
- Worksheet D, Parts III and IV: Added the instructions for new children's and new cancer hospitals to complete these worksheets.
- Worksheet D-4: Clarified the instructions and eliminated the "other" organ category and check off box from the worksheet.
- Worksheet D-5: Added Parts III and IV to model Worksheet A-8-2 and apply reasonable compensation equivalents in the same manner as Worksheet A-8-2 for physicians' services rendered in a teaching hospital effective for cost reporting periods ending on or after June 30, 2014.
- Worksheet E-3, Part V: Added instructions to the worksheet for new children's and new cancer hospitals reimbursed under reasonable cost.
- Worksheet E, Part A:
    - Revised the instructions for line 20 relating to the resident to bed ratio.
    - Clarified the instructions for line 35.03 relating to the pro rata share of the uncompensated care payment.
    - Added line 41.01 and revised the instructions for lines 43 through 46 relating to the additional payment for high percentage of end stage renal disease (ESRD) beneficiary discharges.
- Modified or added instructions to implement sections 105 and 106 of the Protecting Access to Medicare Act of 2014 (PAMA) as follows:
    - Worksheet E, Part A:
        - Revised instructions for line 49 to extend Medicare dependent hospital status through March 31, 2015.
        - Revised instructions for lines 70.96 through 70.98 to extend the low volume adjustment through March 31, 2015.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods Cost Reporting Periods Ending on or After June 30, 2014.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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Step	Worksheet	Instructions
12	D-1, Parts III & IV	Read §§4025, 4025.3 and 4025.4. Only the hospital-based SNF and hospital-based NF must complete Part III, lines 70 *through* 86. All providers must complete Part IV.
13	D-2, Parts I *through* III	Read §§4026 - 4026.3. Complete only those parts that are applicable. Do not complete Part III unless both Parts I and II are completed.
14	L, Parts I *through* III	Read §4064. Complete applicable parts.
15	D-5, Parts I *and* II*, or Parts III and IV*	Read §§4029 - 4029.*4*. Complete *applicable parts*.
16	D-4, Parts I *through* IV	Read §§4028 - 4028.4. Complete only if hospital is a certified transplant center.
17	E-4	Read §§4034. Complete entire worksheet, if applicable.

Part III - Calculation and Apportionment of Hospital-Based Facilities

A. Title XVIII - For SNF Only Reimbursed Under PPS.--

Step	Worksheet	Instructions
1	E-3, Part VI	Read §4033.6. If applicable, complete lines 1 *through* 15 for title XVIII SNF PPS services.
2	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part VI.
3	E-3, Part VI	Complete the remainder of this worksheet, lines 16 *through* 19.

B. Titles V and XIX - For Hospital, Subprovider(s), NF and ICF/MRs.--

Step	Worksheet	Instructions
4	E-3, Part VII	Read §4033.7. If applicable, complete entire worksheet for titles V and XIX services. Use a separate worksheet for each title.

C. Title XVIII - For Swing Bed-SNF and Titles V and XIX - For Swing Bed-NF.--

Step	Worksheet	Instructions
5	E-2	Read §4032. Complete a separate copy of this worksheet (lines 1 *through* 19) for each applicable health care program for each applicable provider component. Only entries applicable to title XVIII are made in column 2. Complete lines 9, 13, and 17 of column 1 for titles V and XIX and columns 1 and 2 for title XVIII.
6	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-2 title XVIII swing bed-SNF only.
7	E-2	Complete the remainder of this worksheet, lines 20 *through* 23.

4004. WORKSHEET S-2 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Hospital and Hospital Health Care Complex Identification Data
Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire

4004.1 Part I - Hospital and Hospital Health Care Complex Identification Data.--The information required on this worksheet is needed to properly identify the provider. The responses to all lines are Yes or No unless otherwise indicated by the type of question.

Line Descriptions

Lines 1 and 2--Enter the street address, post office box (if applicable), the city, State, ZIP code, and county of the hospital.

Lines 3 *through* 17--Enter on the appropriate lines and columns indicated the component names, CMS certification numbers (CCN), core based statistical area (CBSA) codes (non-CBSA (rural) codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the State of Maryland the *n*on-CBSA code is 99921), provider type, and certification dates of the hospital and its various components, if any. Indicate for each health care program (titles V, XVIII, or XIX), the payment system applicable to the hospital and its various components by entering P, T, O, or N in the appropriate column to designate PPS, TEFRA, OTHER, or NOT APPLICABLE, respectively. The "OTHER" payment system includes critical access hospitals (CAHs*)* and cost reimbursed providers *such as new TEFRA providers exempt from the rate of increase limits.*

Column 4--Indicate, as applicable, the number listed below which best corresponds with the type of services provided.

1 = General Short Term
2 = General Long Term
3 = Cancer
4 = Psychiatric
5 = Rehabilitation
6 = Religious Non-Medical Health Care Institution
7 = Children
8 = Alcohol and Drug
9 = Other

If your hospital services various types of patients, indicate "General - Short Term" or "General - Long Term," as appropriate.

NOTE: Long term care hospitals are hospitals organized to provide long term treatment programs with average lengths of stay greater than 25 days. Some hospitals may be certified as other than long term care hospitals, but also have average lengths of stay greater than 25 days.

If your hospital cares for only a special type of patient (such as cancer patients), indicate the special group served. If you are not one of the hospital types described in items 1 through 8 above, indicate 9 for "Other".

Line 3--This is an institution which meets the requirements of §1861(e) or §1861(mm)(1) of the Act and participates in the Medicare program or is a federally controlled institution approved by CMS.

Line 4--The distinct part inpatient psychiatric facility (IPF) is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient psychiatric PPS. (See 42 CFR 412.25) While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

Line 5--The distinct part inpatient rehabilitation facility (IRF) is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient rehabilitation PPS. (See 42 CFR 412.25) While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

Line 6--This is a portion of a general hospital defined as non-Medicare certified not included in lines 4 through 18 which offers a clearly different type of service from the remainder of the hospital.

Line 7--Medicare swing-bed services are paid under the SNF PPS system (indicate payment system as "P"). CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system. Rural hospitals with fewer than 100 beds may be approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided, *as* authorized by §1883 of the Act. (See CMS Pub. 15-1, *chapter 22,* §§2230-2230.6.)

Line 8--Swing bed-NF services are not payable under the Medicare program but are payable under State Medicaid programs if included in the Medicaid State plan. This is a rural hospital with fewer than 100 beds that has a Medicare swing bed agreement approved by CMS and that is approved by the State Medicaid agency to use these beds interchangeably as hospital and other nursing facility beds, with payment based on the specific level of care provided. This is authorized by §1913 of the Act.

Line 9--This is a distinct part skilled nursing facility that has been issued an SNF identification number and which meets the requirements of §1819 of the Act. For cost reporting periods beginning on or after October 1, 1996, a complex cannot contain more than one hospital-based SNF or hospital-based NF.

Line 10--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (See 42 CFR 442.300 and 42 CFR 442.400 for standards for other nursing facilities, for other than facilities for the mentally retarded, and for facilities for the mentally retarded.) If your State recognizes only one level of care, i.e., skilled, do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care, i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only. The contractor will reject a cost report attempting to report more than one nursing facility.

If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 10 to 10.01 and enter the data on that line. Note: Subscripting is allowed only for the purpose of reporting an ICF/MR.

Line 11--This is any other hospital-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 12--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA.

Line 13--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ASC operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

Line 14--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 6, 7, and 8.

Lines 15 and 16--Enter the applicable information for rural health clinics (RHCs) on line 15 and for federally qualified health centers (FQHCs) on line 16. These lines are used by RHCs and/or FQHCs which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report them on subscripts of line 15. If you have more than one FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-04 (Medicare Claims Processing Manual), chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See *§*4010 for further instructions.

Line 17--This line is used by hospital-based community mental health centers (CMHCs). Subscript this line as necessary to accommodate multiple CMHCs (lines 17.00-17.09). Also subscript this line to accommodate CORFs (lines 17.10-17.19), OPTs (lines 17.20-17.29), OOTs (lines 17.30-17.39) and OSPs (lines 17.40-17.49). (See §4095 Exhibit 2, Table 4, Part III.)

Line 18--If this facility operates a renal dialysis facility (CCN 2300-2499), a renal dialysis satellite (CCN 3500-3699), and/or a special purpose renal dialysis facility (CCN 3700-3799), enter in column 2 the applicable CCN. Subscript this line as applicable.

Line 19--For any component type not identified on lines 3 through 1*8*, enter the required information in the appropriate column.

Line 20--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See CMS Pub. 15-2, chapter 1, §§102.1-102.3 for situations where you may file a short period cost report.)

Line 21--Indicate the type of control under which the hospital operates:

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, City-County
9 = Governmental, County
10 = Governmental, State
11 = Governmental, Hospital District
12 = Governmental, City
13 = Governmental, Other

Line 22--Does your facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? Enter in column 1 "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle Amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.

Line 22.01--For cost reporting periods that overlap or begin on or after October 1, 2013, did this hospital receive interim uncompensated care payments? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period beginning on or after October 1. *For cost reporting periods that begin on October 1, complete only column 2 (i.e, enter "N" for no in column 1 or leave column 1 blank). The responses to Worksheet S-2, columns 1 and 2, correspond to Worksheet E, Part A, columns 1 and 2, respectively, for lines 35 through 35.02.*

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if days are based on the date of discharge. Is the method of identifying the days in

the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.

NOTE: For lines 24 and 25, columns 1 through 6 are mutually exclusive. For example, if patient days are entered in column 1, those days may not be entered in any other columns.

Line 24--If line 23, *column 1,* is "3" and this is an IPPS provider, enter the in-state Medicaid paid days in column 1 (report *these days* on *Worksheet* S-3, Part I, *column 7,* line 1, and *lines* 8 through 13, as applicable), the in-state Medicaid eligible but unpaid days in column 2 (report *these days* on *Worksheet* S-3, Part I, *column 7,* line 2 *for adult and pediatric patients* and *line* 13 *for nursery patients*, as applicable), the out-of-state Medicaid paid days in column 3 (report *these days* on *Worksheet* S-3, Part I, *column 7,* line 2 *for adult and pediatric patients* and *line* 13 *for nursery patients*, as applicable), the out-of-state Medicaid eligible but unpaid days in column 4 (report *these days* on *Worksheet* S-3, Part I, *column 7,* line 2 *for adult and pediatric patients* and *line* 13 *for nursery patients*, as applicable), *the* Medicaid HMO paid and eligible but unpaid days in column 5 (report *these days* on *Worksheet* S-3, Part I, *column 7,* line 2 *for adult and pediatric patients* and *line* 13 *for nursery patients*, as applicable). Enter only labor and delivery days (reported on *Worksheet* S-3, Part 1, *column 7,* line 32) as "Other Medicaid days" in column 6. If line 23, *column 1,* is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line. See 42 CFR 412.106(a)(1)(ii) and 412.106(b)(4).

Line 25--If line 23, *column 1,* is "3" and this provider is an IRF or contains an IRF unit, enter the in-state Medicaid paid days in column 1, (report *IRF days* on *Worksheet* S-3, Part I, *column 7,* line 1 *or* IRF unit *days on Worksheet S-3, Part I*, *column 7, line 17*), the in-state Medicaid eligible but unpaid days in column 2 (report *IRF days* on *Worksheet* S-3, Part I, *column 7,* line 2 or IRF unit *days on Worksheet S-3, Part I*, *column 7, line 4*), the out-of-state Medicaid paid days in column 3 (report *IRF days* on *Worksheet* S-3, Part I, *column 7,* line 2 or IRF unit *days on Worksheet S-3, Part I*, *column 7, line 4*), the out-of-state Medicaid eligible but unpaid days in column 4 (report *IRF days* on *Worksheet* S-3, Part I, *column 7,* line 2 or IRF unit *days on Worksheet S-3, Part I*, *column 7, line 4*), *the* Medicaid HMO paid and eligible but unpaid days in column 5 (report *IRF days* on *Worksheet* S-3, Part I, *column 7,* line 2 or IRF unit *days on Worksheet S-3, Part I*, *column 7, line 4*). Do not enter any days in column 6 for cost reporting periods beginning on or after October 1, 2012. If line 23, *column 1,* is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line.

Line 26--For the Standard geographic classification (not wage), what is your status at the **beginning** of the cost reporting period. Enter "1" for urban or "2" for rural.

Line 27--For the Standard geographic classification (not wage), what is your status at the **end** of the cost reporting period. Enter "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.

Lines 28 *through* 34--Reserved for future use.

Line 35--If this is a sole community hospital (SCH), enter the number of periods (0, 1 or 2) within this cost reporting period that SCH status was in effect.

Line 36--Enter the beginning and ending dates of SCH status during this cost reporting period. Subscript line 36 if more than *one* period is identified for this cost reporting period and enter multiple dates. Multiple dates are created where there is a break in the date between SCH status, i.e., for calendar year provider SCH status dates are 1/1/2010 *through* 6/30/2010 and 9/1/2010 *through* 12/31/2010.

Line 37--If this is a Medicare dependent hospital (MDH), enter the number of periods within this

cost reporting period that MDH status was in effect.

Line 38--Enter the beginning and ending dates of MDH status during this cost reporting period. Subscript line 38 if more than *one* period is identified for this cost reporting period and enter multiple dates.

Line 39--For cost reporting periods that overlap or begin on or after October 1, 2010, does the hospital qualify for the inpatient hospital adjustment for low volume hospitals for a portion of the cost reporting period? Enter in column 1 "Y" for yes or "N" for no. If column 1 is "Y", does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2, "Y" for yes or "N" for no. Hospitals are required to request low-volume status in writing to their contractor and provide documentation that they meet the mileage criteria.

The response to these questions determines the completion of the low-volume calculation adjustment.

NOTE: 42 CFR 412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for federal fiscal year (FFYs) 2011 through 2013 as follows:

•Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and
•Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

•Be more than 15 road miles from the nearest subsection (d) hospital; and
•Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data as determined by CMS.

Lines 40 *through* 44--Reserved for future use.

Line 45--Does your facility qualify and receive capital payments for disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no.

Line 46--Are you eligible for the exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f)? Enter "Y" for yes or "N" for no. If yes, complete Worksheets L, Part III and L-1.

Line 47--Is this a new hospital under 42 CFR 412.300(b) (PPS capital)? Enter "Y" for yes or "N" for no for the respective programs.

Line 48--If line 47 is yes, do you elect full federal capital payment. Enter "Y" for yes or "N" for no for the respective programs.

Lines 49 *through* 55--Reserved for future use.

NOTE: CAHs complete question 107 in lieu of question 57.

Line 56--Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.

Line 57--If line 56 is yes, is this the first cost reporting period in which you are training residents in approved programs. Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, were residents training during the first month of the cost reporting period. Enter "Y" for yes or "N" for no in column 2. If column 2 is yes, complete Worksheet E-4. If column 2 is "N" complete Worksheets D, Parts III and IV and D-2, Part II, if applicable.

Line 58--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-1, chapter 21, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.

Line 59--Are you claiming costs of intern & resident in unapproved programs on *Worksheet A, column 7,* line 100? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-2, Part I.

Line 60--Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 42 CFR 413.85? Enter "Y" for yes or "N" for no. If yes, you must identify such costs in the applicable column(s) of Worksheet D, Parts III and IV, to separately identify nursing and allied health (paramedical education) from all other medical education costs.

Requirements During Five Year Period Following Implementation of Increases to Hospitals' FTE Resident Caps Under Section 5503 of the ACA, Lines 61 and Subscripts--Section 5503 of the ACA states that a hospital that receives an increase to its FTE resident cap under section 5503 shall ensure, during the 5-year period beginning on July 1, 2011, that:

> (I) The number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to the date of enactment of section 5503; and
>
> (II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency.

Failure to comply with either of these two requirements, known as the 3-year primary care average requirement (I) and the 75 percent test (II) means permanent removal of all section 5503 slots from the earliest applicable cost reporting period under the regulations at 42 CFR 413.79(n)(2).

Line 61--Did your hospital receive FTE slots under section 5503 of the ACA? Enter "Y" for yes or "N" for no in column 1. If "Y", enter the number of IME section 5503 slots awarded in column 4 and direct GME section 5503 slots awarded in column 5. The number of IME and/or direct GME slots entered here should be the amounts on the award letter from CMS. Complete the subscripts of line 61. If "N" for no, do not complete columns 4 or 5 and subscripts of line 61.

NOTE: Effective for portions of cost reporting periods occurring on or after July 1, 2011, do not complete line 61, columns 2 and 3. This information is now reported on line 61.01, columns 2 and 3.

Line 61.01--Effective for portions of cost reporting periods occurring on or after July 1, 2011, enter the average unweighted number of primary care FTE residents from the hospital's three most recent cost reports ending and submitted to the contractor before March 23, 2010. See 42 CFR 413.75(b) for the definition of "primary care resident". Enter the 3-year primary care average for IME in column 2. The source of the primary care IME FTE residents is the rotation schedules submitted by the provider to support its cost reports for the three most recent cost reports ending and submitted to the contractors prior to March 23, 2010. Any audit adjustments to these IME primary care FTE residents must be taken into account in computing the three year average. Exclude OB/GYN and general surgery FTE residents. This primary care average is based on the hospital's total primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Enter the average unweighted number of primary care FTE residents for direct GME in column 3. This primary care average is based on the hospital's total unweighted primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If

3121, was amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002. Note that for SCHs and EACHs, the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012, regardless of bed size, and from March 1, 2012 through December 31, 2012, for SCHs and EACHs with 100 or fewer beds. Rural hospitals with 100 or fewer beds are also extended through December 31, 2012. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.

Line 121--Did this facility incur and report costs (direct or indirect) in the "Implantable Devices Charged to Patients" (line 72) cost center as indicated in the Federal Register, Vol. 73, number 161, dated August 19, 2008, page 48462 bearing the revenue codes established by the National Uniform Billing Committee (NUBC) for high cost implantable devices. Enter "Y" for yes or "N" for no.

Lines 122 *through* 124--Reserved for future use.

Line 125--Does your facility operate a transplant center(s)? Enter "Y" for yes or "N" for no in column 1. If yes, enter the certification dates and termination dates*, if applicable,* on lines 126 through 133.

Line 126--If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date in column 2. Also complete Worksheet D-4.

Line 127--If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date in column 2. Also complete Worksheet D-4.

Line 128--If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date in column 2. Also complete Worksheet D-4.

Line 129--If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 130--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification date for kidney transplants in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 131--If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 132--If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 133--Use this line if your facility contains a Medicare certified transplant center not specifically identified on lines 126 through 132. Enter the certification date in column 1 and termination date in column 2, if applicable. Subscript this line as applicable*; however, do not* complete a separate Worksheet D-4 for each Medicare certified transplant center type. *For organs identified on this line, enter the corresponding cost on Worksheet A, line 112 and subscripts as applicable.*

Line 134--If this is an organ procurement organization (OPO), enter the OPO CCN number in column 1 and termination date, if applicable, in column 2.

Lines 135 *through* 139--Reserved for future use.

Line 140--Are there any related organization or home office costs claimed as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, complete Worksheet A-8-1. If this facility is part of a chain and you are claiming home office costs, enter

in column 2 the home office chain number and complete lines 141 through 143. See CMS Pub. 15-1, chapter 21, §2150 for a definition of a chain organization.

Line 141--Enter the name of the chain home office in column 1, the home office contractor name in column 2, and the home office contractor number in column 3.

Line 142--Enter the street address and P. O. Box (if applicable) of the *h*ome *o*ffice.

Line 143--Enter the city, State and ZIP code of the *h*ome *o*ffice.

Line 144--Are provider based physicians' costs included in Worksheet A? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-2.

Line 145--If you are claiming costs for renal services on Worksheet A, line 74, are they inpatient services only? Enter "Y" for yes or "N" for no. If yes, do not complete Worksheet S-5 and the Worksheet I series.

Line 146--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

Line 147--Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.

Line 148--Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.

Line 149--Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.

Lines 150 *through* 154--Reserved for future use.

Lines 155 *through* 161--If you are a hospital (public or non-public) that qualifies for an exemption from the application of the lower of cost or charges *principle* as provided in 42 CFR 413.13, indicate the component and/or services for titles V, XVIII and XIX that qualify for the exemption by entering in the corresponding box a "Y" for yes, if you qualify for the exemption, or an "N" for no, if you do not qualify for the exemption. Subscript as needed for additional components. For title XVIII providers, a response of "Y" does not subject the provider to *the* LCC *principle*.

Lines 162 *through* 164--Reserved for future use.

Line 165--Is the hospital part of a multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. (For purposes of this question, only answer yes if the main campus and the off-site campus(es) are classified as section 1886(d) hospitals, or they are located in Puerto Rico).

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, ZIP code in column 3, geographic CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. Enter the information in columns 0 through 5 for the main campus first, and then enter the information in each column for the subordinate campuses, in any order. For example, for the main campus, enter on line 166 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. For the first subordinate campus, enter on line 166.01 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus.

Line 167--Is this hospital/campus a meaningful user of electronic health record (EHR) technology in accordance *§*1886(n) of the Social Security Act as amended by the section 4102 of the American Recovery and Reinvestment Act (ARRA) of 2009? Enter "Y" for yes or "N" for no.

4005. WORKSHEET S-3 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

This worksheet consists of five parts:

Part I	-	Hospital and Hospital Health Care Complex Statistical Data
Part II	-	Hospital Wage Index Information
Part III	-	Hospital Wage Index Summary
Part IV	-	Hospital Wage Related Costs
Part V	-	Hospital Contract Labor and Benefit Costs

4005.1 Part I - Hospital and Hospital Health Care Complex Statistical Data.--This part collects statistical data regarding beds, days, FTEs, and discharges.

Column Descriptions

Column 1--Enter the Worksheet A line number that corresponds to the Worksheet S-3 component line description.

Column 2--Refer to 42 CFR 412.105(b) and Vol. 69, No. 154 of the FR dated August 11, 2004, pages 49093 through 49098 to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period.

A bed means an adult bed, pediatric bed, portion of inpatient labor/delivery/postpartum (LDP) room (also referred to as birthing room) bed when used for services other than labor and delivery, or newborn ICU bed (excluding newborn bassinets) maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in post-anesthesia, post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments (however, see exception for labor and delivery department), nurses' and other staff residences, and other such areas that are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-1, chapter 22, §2205.)

For cost reporting periods beginning prior to October 1, 2012, beds in distinct ancillary labor and delivery rooms and the proportion of LDP room (birthing room) beds used for labor and delivery services are not a bed for these purposes. (See Vol. 68, No. 148 of the FR dated August 1, 2003, page 45420.)

For cost reporting periods beginning on or after October 1, 2012, in accordance with Vol. 77, No. 170 of the FR dated August 31, 2012, pages 53411 through 53413, beds in distinct labor and delivery rooms, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count in accordance with 42 CFR 412.105(b) and are to be reported on line 32. Furthermore, the proportion of the inpatient LDP room (birthing room) beds used for ancillary labor and delivery services is considered part of the hospital's available bed count.

Column 3--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 2 by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

Column 4--CAHs accumulate the aggregate number of hours all CAH patients spend in each category on lines 1 and 8 through 12. This data is for informational purposes only.

Columns 5 through 7--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO days except where required (lines 2 through 4, columns 6 and 7*; line 13, column 7*), organ acquisition, or observation bed days in these

columns. *Nursery days (all the days during which a newborn infant occupies a nursery) are reported on line 13, column 7 and include the in-state paid Medicaid days; in-state Medicaid eligible but unpaid days; out-of-state Medicaid paid days; out-of-state Medicaid eligible but unpaid days paid; and Medicaid HMO paid and eligible but unpaid days.* Observation bed days are reported in columns 7 (title XIX) and 8 (total), line 28. For LTCH, enter in column 6 on the applicable line the number of covered Medicare days (from the PS&R) and enter in column 6, line 33 the number of non-covered days (from provider's books and records) for Medicare patients.

Report the program days for PPS providers (acute care hospital, IPF, IRF, and LTCH) in the cost reporting period in which the discharge is reported. This also applies to providers under the TEFRA/PPS blend. TEFRA providers should report their program days in the reporting period in which they occur.

NOTE: Medicaid days for Medicaid recipients who are members of an HMO as well as *out-of-state* days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and *nursery* days are reported on lines 2, 3, 4 *or 13* in accordance with 42 CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7 do not include days for Medicaid patients who are also members of an HMO, out of State Medicaid days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and *nursery* days.

Column 8--Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column. This amount will not equal the sum of columns 5 through 7 when the provider renders services to other than titles V, XVIII, or XIX patients.

Column 9--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(f) for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 16 or 17, respectively, of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs and in accordance with the Federal Register, Vol. 70, number 156, dated August 15, 2005, pages 47929 *and 479*30 for IRFs.

Columns 10 and 11--The average number of FTE employees for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first week of the first payroll period at the beginning of each quarter, and divide the sum by 160 (4 times 40). When semiannual data are used, add the total number of paid hours on the first week of the first payroll period of the first and seventh months of the period. Divide this sum by 80 (2 times 40). Enter the average number of paid employees in column 10 and the average number of nonpaid workers in column 11 for each component, as applicable.

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.) Enter the title XVIII Medicare Advantage (MA) discharges in column 13, line 2. *For cost reporting periods ending on or after June 30, 2014, enter the title XIX managed care discharges in column 14, line 2. For columns 13 and 14, line 2 is a subset of column 15, line 1.*

Column 15--Enter the number of discharges including deaths (excluding newborn and DOAs) for all classes of patients for each component.

Line Descriptions

Line 1--For cost reporting periods beginning before October 1, 2012, exclude from column 2 the portion of LDP room (birthing room) beds used for ancillary labor and delivery services, but include on this line beds used for routine adult and pediatric services (postpartum). In accordance with the instructions in Vol. 68, No. 148 of the FR dated August 1, 2003, page 45420, compute this proportion (off the cost report) by multiplying the total number of occupied and unoccupied available beds in the LDP room by the percentage of time these beds were used for ancillary labor and delivery services. An example of how to calculate the "percentage of time" would be for a hospital to determine the number of hours for the cost reporting period during which each LDP room maternity patient received labor and delivery services and divide the sum of those hours for all such patients by the sum of the total hours (for both, ancillary labor and delivery services and for routine postpartum services) that all maternity patients spent in the LDP room during that cost reporting period. Alternatively, a hospital could calculate an average percentage of time maternity patients received ancillary labor and delivery services in an LDP room during a typical month.

For cost reporting periods beginning on or after October 1, 2012, include all the available LDP room (birthing room) beds in the available bed count in column 2. (See Vol. 77, No. 170 of the FR dated August 31, 2012, pages 53411 through 53413.) The proportion of available LDP room beds related to the ancillary labor and delivery services must not be excluded from column 2 for those cost reporting periods.

In columns 5, 6, 7 and 8, enter the number of adult and pediatric hospital days excluding the SNF and NF swing bed, observation bed, and hospice days. In columns 6 and 7, also exclude HMO days. **Do not include in column 6 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days**. Include these days only in column 8. However, do not include employee discount days in column 8.

Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, *line 32*) must not be included on this line.

Line 2--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans *(§1876 of the Act)*. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 1, column 7.

Line 3--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans *(§1876 of the Act) that* pertain to IPF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 16, column 7.

Line 4--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans *(§1876 of the Act) that* pertain to IRF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 17, column 7.

Line 5--Enter the Medicare covered swing bed days (which are considered synonymous with SNF swing bed days) for all title XVIII programs where applicable. (See 42 CFR 413.53(a)(2).) Exclude all MA days from column 6, include the MA days in column 8.

Line 6--Enter the non-Medicare covered swing bed days (which are considered synonymous with NF swing bed days) for all programs where applicable. (See 42 CFR 413.53(a)(2).)

Line 7--Enter the sum of lines 1, 5, and 6.

Lines 8 *through* 13--Enter the appropriate statistic applicable to each discipline for all programs.

Line 14--Enter the sum of lines 7 *through* 13 for columns 2 *through* 8, and for columns 12 *through* 15, enter the amount from line 1. For columns 9 *through* 11, enter the total for each from your records.

Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, *line 32*) must not be included on this line.

Line 15--Enter the number of outpatient visits for CAHs by program and total. An outpatient CAH visit is defined in 42 CFR 413.70(b)(3)(iii).

Line 16--Enter the applicable data for the IPF subprovider.

Line 17--Enter the applicable data for the IRF subprovider.

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line.

Line 19--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX, however, do not complete line 20. If you answered yes to line 92 of Worksheet S-2, Part I, complete all columns.

Line 20--Enter nursing facility days if you have a separately certified nursing facility for title XIX or you answered yes to line 92 of Worksheet S-2, Part I. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/MR, subscript this line to 20.01 and enter the ICF/MR days. Do not report any nursing facility data on line 20.01.

Line 21--Enter data for an other long term care facility.

Line 22--If you have more than one hospital-based HHA, subscript this line.

Line 23--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 24--Enter days applicable to hospice patients in a distinct part hospice.

Line 24.10--Effective for cost reporting periods beginning on or after October 1, 2011, enter in column 8, the days applicable to hospice patients currently under a valid hospice election who occupy general inpatient routine beds under a contractual arrangement between the hospital and hospice to provide general inpatient hospice and/or respite care services.

Line 25--CMHCs enter the number of partial hospitalization days as applicable. For reporting of multiple facilities follow the same format used on Worksheet S-2, Part I, line 17.

Line 26--Enter the number of outpatient visits for FQHC and RHC. If you have both or multiples of one, subscript the line. If the RHC/FQHC is approved to file a consolidated cost report all data is reported in aggregate as a single provider and must use either line 26 with no subscripting or must use a single subscript of line 26 representing the consolidated RHC/FQHC. If a consolidated RHC and FQHC cost reports exists, each consolidated cost report will use a separate line.

Line 28--Enter the total observation bed days in column 8. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the cost of observation beds since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation bed area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed.

Line 29--Enter in column 6, the total number of ambulance trips, as defined by §4531(a)(1) of the BBA. Do not subscript this line.

Line 30--Enter in column 8, the employee discount days if applicable. These days are used on Worksheet E, Part A, line 31 in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3 in the calculation of the LIP adjustment.

Line 31--Enter in column 8, the employee discount days, if applicable, for IRF subproviders.

Line 32--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 2, the total number of available beds located in the distinct ancillary labor and delivery rooms. In accordance with 42 CFR 412.105(b) and Vol. 77, No. 170 of the FR dated August 31, 2012, pages 53411 through 53413, distinct ancillary labor and delivery room beds, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count. These beds are not included in the inpatient routine beds reported on line 1. Note that the available bed days reported in column 3 are reduced on Worksheet E, Part A by the equivalent of outpatient labor and delivery days from line 32.01.

Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 6 the number of labor/delivery inpatient days for title XVIII. (See Vol. 78, No. 160 of the FR dated August 19, 2013, pages 50730 through 50733.)

Effective for cost reporting periods beginning on or after October 1, 2009, enter in column 7 the number of labor/delivery inpatient days for title XIX and in column 8 the total number of labor/delivery inpatient days for the entire hospital. (See Vol. 74, No. 165 of the FR dated August 27, 2009, pages 43899 through 43901.)

For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see CMS Pub. 15-1, chapter 22, §2205.2). Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 32. These days must not be reported on Worksheet S-3, Part I, line 1 or line 14.In the case where the maternity patient is in a single multipurpose labor/delivery/postpartum (LDP) room (also referred to as a birthing room), hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (*postpartum*) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32.

Line 32.01--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 8 the equivalent days for the entire hospital that are attributable to outpatient services provided in the distinct ancillary labor and delivery room. Calculate the number of days by dividing the total number of hours attributable to the outpatient services by 24, and round to the nearest whole day. These total outpatient hours include the hours for outpatients occupying the distinct ancillary labor and delivery room until they are admitted as inpatients or are discharged from the hospital. For example, one patient is admitted as an inpatient after first occupying the distinct ancillary labor and delivery room bed for 8 hours. Therefore, for this patient, 8 hours would be included in the sum of the total hours used to compute equivalent days to be entered on line 32.01. Another patient is admitted to the distinct ancillary labor and delivery room for monitoring of possible labor or for a sonogram, etc. After spending 6 hours in this department (room), this patient is discharged from the hospital without being admitted as an inpatient. Therefore, for this patient, 6 hours would be included in the sum of the total hours used to compute the equivalent days to be entered on line 32.01. These outpatient labor and delivery days are used on Worksheet E, Part A to reduce the available bed days reported on line 32 so that

only those distinct ancillary labor and delivery room beds which are occupied by inpatients or are unoccupied are ultimately counted as "beds."

Line 33--See instructions for columns 5 through 7 of this worksheet.

4005.2 Part II - Hospital Wage Index Information.--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II, III and IV are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete Worksheet S-3, Parts II, III, and IV for IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to IPPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

NOTE: Lines 4 and 22 apply to physician's Part A administrative costs.

NOTE: Capital related salaries, hours, and wage-related costs associated with lines 1 and 2 of Worksheet A must not be included on Worksheet S-3, Parts II and III.

Column 2

General instructions for completing column 2:

1. For each line item (except for wage-related costs on lines 17 through 25 or as otherwise indicated), report in column 2, the direct salaries and wages, including amounts for related paid vacation, holiday, sick leave, other paid-time-off (PTO), severance pay, and bonus pay for personnel associated with the line item.
2. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in column 2, with related direct salaries and wages to be considered an allowable cost for the wage index.
3. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in the same cost center as the related direct salaries and wages. For example, do NOT report the direct salaries and wages of an employee in one cost center and report the employee's paid vacation in a different cost center.
4. To be considered an allowable salary cost (i.e., direct salaries and wages plus paid vacation, holiday, sick leave, other PTO, and severance pay), the associated hours must also be reported in column 5. (See exceptions in column 5 instructions for bonus pay and overtime pay. Also, for wage-related costs, there are no associated hours.)
5. Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

NOTE: Methodology for including vacation/holiday/sick/other PTO accruals in the wage index:

PTO salary cost--The required source for costs on Worksheet A is the General Ledger (see §4013 and 42 CFR 413.24(e)). Worksheet S-3, Part II (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the General Ledger. A hospital's current year General Ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). Hospitals and contractors are to include on Worksheet S-3, Part II the current year PTO cost incurred as reflected on the General Ledger; that is, both the current year PTO cost paid and the current year PTO accrual. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year General Ledger and should not be included on the hospital's current year Worksheet S-3, Part II.)

PTO hours--The source for PTO paid hours on Worksheet S-3, Part II is the Payroll Report. Hours are included on the Payroll Report in the period in which the associated PTO expense is paid. Hospitals and contractors are to include on Worksheet S-3, Part II, the PTO hours that are reflected on the current year Payroll Report, which includes hours associated with PTO cost that was expensed in the prior year but paid in the current year. The time period must cover the weeks that best matches the provider's cost reporting period. (Hours associated with PTO cost expensed in the current year but not paid until the subsequent year (current year PTO accrual) are not included on the current year Payroll Report and should not be included on the hospital's current year Worksheet S-3, Part II.)

Although this methodology does not provide a perfect match between paid PTO cost and paid PTO hours for a given year, it should approximate an actual match between cost and hours. Over time, any variances should be minimal.

Line 1--Enter from Worksheet A, column 1, line 200, the direct salaries and wages, including the amounts for related paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay, paid to hospital employees. See Worksheet A instructions (§ 4013).

Lines 2 *through* 10--The amounts to be reported must be adjusted for vacation, holiday, sick, other paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 8 the salaries for employees associated with excluded areas lines 9 and 10.

Line 2--Enter the salaries for directly-employed Part A non-physician anesthetist salaries (for rural hospitals that have been granted CRNA pass through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract CRNA cost must be included on line 11. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract Part A CRNAs.

Do not include physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the contractor. Do not include salary costs for physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 4--Enter the physician Part A administrative salaries, (excluding teaching physician salaries), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 7. Subscript this line and report salaries for Part A teaching physicians on line 4.01.

Lines 5 and 6--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1. Under Medicare, these services are related to patient care and billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics (RHC) and federally qualified health centers (FQHC) included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Report on line 6 the non-physician salaries reported for hospital-based RHC and FQHC services included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Do not include on these lines amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.

Line 7--Enter from Worksheet A the salaries reported in column 1 of line 21 for interns and residents. Subscript this line and report salaries for contracted interns and residents in an approved program on line 7.01. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract intern and resident costs must be included on line 11. DO NOT include contract intern and residents costs on line 13. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract interns and residents.

Line 8--If you are a member of a chain or other related organization as defined in CMS Pub. 15-1, chapter 21, §2150, enter from your records, the wages and salaries for home office related organization personnel that are included in line 1.

Lines 9 and 10--Enter on line 9 the amount reported on Worksheet A, column 1 for line 44 for the SNF. On line 10, enter from Worksheet A, column 1, the sum of lines 20, 23, 40 through 42, 45, 45.01, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194. DO NOT include on lines 9 and 10 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for Line 10.

General Instructions for Contract Labor:

In general, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, then other documentation is necessary, such as a representative sample of invoices which specify the wage costs, hours, and non-labor costs or a signed declaration from the vendor in conjunction with a sample of invoices. Hospitals must be able to provide such documentation when requested by the contractor. A hospital's failure to provide adequate supporting documentation may result in the cost being disallowed for the wage index. Report only personnel costs associated with the contract. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule. That is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3.

Line 11--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined below. Do not include costs applicable to excluded areas reported on line 9 and 10. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 7.01, respectively). Include on this line contract pharmacy and laboratory wage costs as defined below.

Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services. Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Contract pharmacy services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

Contract laboratory services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

If you have no contracts for direct patient care as defined above, enter a zero in column 2. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 2.

Line 12--Enter the amount paid for ***contracted top level management services, and other*** **contract management and administrative services** furnished under contract, rather than by employees. Include on this line contract management and administrative services associated with cost centers other than those listed on lines 26 through 43 (and their subscripts) of this worksheet that are included in the wage index.

Contracted Top Level Management: Include the amount paid for **top level management services**, as defined below, furnished under contract rather than by employees. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract top level management services DO NOT include the following: physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the top level management contracts listed above. Per instructions on Worksheet S-2, Part II, for top level management contracts, submit to your Medicare contractor the aggregate wages and hours.

Other Contract Management and Administrative Services: Examples of other contract management and administrative services that would be reported on line 12 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines.

Line 13--Enter from your records the amount paid under contract (*in accordance with the general instructions above for contract labor*) for Part A physician services - administrative, excluding teaching physician services. DO NOT include contract I & R services (to be included on line 7). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 15).

Line 14--Enter the salaries and wage-related costs (as defined on lines 17 and 18) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 8 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office/related organization salary to the hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 15.

If a wage related cost associated with the home office is not “core” (as described in the Worksheet S-3, Part IV) and is not a category included in “other” wage related costs on line 18 (see Worksheet S-3, Part IV and line 18 instructions below), the cost cannot be included on line 14. For example, if a hospital’s employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 18, any parking cost associated with home office staff cannot be included on line 14.

Line 15--Enter from your records the salaries and wage-related costs for Part A physician services - administrative, excluding teaching physician Part A services from the home office allocation and/or related organizations.

Line 16--Enter from your records the salaries and wage-related costs for Part A teaching physicians' from the home office allocation and/or related organizations. Also report on this line Part A teaching physicians salaries under contract.

Lines 17 *through* 25--In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. For pension and executive deferred compensation costs see the instructions below in Part IV.

For those wage-related costs that are not covered by Medicare reasonable cost principles, a hospital shall use generally accepted accounting principles (GAAP). For example, for purposes of the wage index, disability insurance cost should be developed using GAAP. Hospitals are required to complete Worksheet S-3, Part IV, a reconciliation worksheet to aid hospitals and contractors in implementing GAAP when developing wage-related costs. Upon request by the contractor or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the wage-related costs. If a hospital does not complete Worksheet S-3, Part IV, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the contractor may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP.

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see CMS Pub. 15-1, chapter 10, §1000. For GAAP, see FASB 57.) If a hospital's consolidation methodology is not in accordance with GAAP or if there are any amounts in the methodology that cannot be verified by the contractor, the contractor may apply the hospital's cost to charge ratio to reduce the related party expenses to cost.

NOTE: All wage-related costs, including FICA, workers compensation, and unemployment compensation taxes, associated with physician services are to be allocated according to the services provided; that is, those taxes and other wage-related costs attributable to Part A administrative services must be placed on line 22, to Part A teaching services must be placed on line 22.01, and to Part B (patient care services) must be placed on line 23. Line 17 must not include wage-related costs that are associated with physician services.

Line 17--Enter the core wage-related costs from Worksheet S-3, Part IV, line 24. (See note below for costs that are not to be included on line 17). Only the wage-related costs reported on Worksheet S-3, Part IV, line 24 are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physicians Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel. (See lines 14, 15, and 20 through 25.)

Health Insurance and Health-Related Wage Related Costs:

The following are the allowable health insurance and health-related costs for the wage index.

1) Purchased Health Insurance:
- Premium costs.
- Costs paid to external organizations for plan administration.

2) Self (or Self-Funded) Health Insurance:
- Costs paid to external organizations for plan administration.
- Without a Third-Party Administrator (TPA).
  - Costs the hospital incurs in providing services under the plan to its employees. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.) *Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.*
  - Hospital's payment to unrelated health care providers for services rendered, under the plan, to hospital's employees.
- With a TPA.
  - Amount the TPA pays to the hospital or other health care providers for services rendered under the plan. (For domestic claims, the hospital must provide documentation from its TPA to demonstrate that payments for services rendered to employees are based on a discount from full charges. Also, the payments must be reasonable; that is, the costs included for domestic claims must not exceed the amount that commercial insurers pay the hospital for the same services rendered to nonemployees.) *Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.*

    NOTE: Hospitals and contractors are not required to remove from domestic claims costs, the personnel costs that are associated with hospital staff who deliver the services to employees.

3) Health-Related Services: *I*npatient and outpatient health services that are not covered under the hospital's health insurance plan, but are provided to employees at no cost or at a discount, for example, employee physicals, flu shots, *smoking cessation, and weight control programs, are to be included as a core wage-related cost*. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.)

NOTE: Hospitals and contractors are not required to remove from domestic claims costs, the personnel costs that are associated with hospital staff who deliver the services to employees.

Line 18--Enter the wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 18.) In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

a. The cost is not listed on Worksheet S-3, Part IV,

b. The wage-related cost has not been furnished for the convenience of the provider,

c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and

d. The total cost of the particular wage-related cost for employees whose services are paid under IPPS exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 4, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 19--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 9 and 10.

Lines 20 *through* 25--Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage related costs plus the other wage-related costs. Do not include wage-related costs for excluded areas reported on line 19. Subscript line 22 and report the wage related costs for Part A teaching physicians reported on line 4.01, on line 22.01. On line 23, do not include wage-related costs related to non-physician salaries reported for Hospital- based RHCs and FQHCs services included on Worksheet A, column 1, lines 88 and/or 89, as applicable. These wage-related costs are reported separately on line 24.

Lines 26 *through* 43--Enter the direct salary and wages with related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay from Worksheet A column 1 for the appropriate cost center identified on lines 26 through 43, column 2.

These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 5, sum of lines 9 and 10 divided by the result of column 5, line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01 and 8 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 7 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Line 26--Salaries and hours reported on this line correlate to the salaries reported on line 4, column 1 of Worksheet A, for the personnel working in the Employee Benefit Department, or the Human Resources Department. Do not report costs or hours associated with other hospital employees on this line.

Lines 28, 33, and 35--Enter the amount paid for services performed **under contract** *(in accordance with the general contract labor instructions above)*, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. Continue to report on the standard lines (line 27, 32, and 34), the amounts paid for services rendered by employees not under contract.

Line 28--A&G costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 28 the contract services that are included on Worksheet A, line 5 and subscripts, column 2 ("Administrative and General"). Contract information and data processing services, legal, tax preparation, cost report preparation, and purchasing services are examples of contract labor costs that would be included on this line and must not be reported on lines 11 or 12. Do not include on line 28 the costs for top level management contracts (these costs are reported on line *12*).

Lines 32 through 35--All hospitals must incur costs for housekeeping and dietary services, either direct, under contract, or both. It is not acceptable to report zeroes for housekeeping or dietary services. Report wages and hours for housekeeping services on either line 32 (direct) or line 33 (contract), and for dietary services, on either line 34 (direct) or line 35 (contract). Hospitals are encouraged to ensure that their contracts clearly specify the salaries, wages, and hours related to all of their contract labor. If, in rare instances, hours for these services cannot be determined exactly from the contract, determine the hours based on a reasonable estimation. Examples of reasonable estimates are regional average hourly rates, including an average of the wages and hours for dietary and housekeeping services of other hospitals in the same CBSA. Hospitals also may conduct time studies to determine hours worked. If regional averages or time studies cannot be used, data from the Bureau of Labor Statistics may be used to obtain average wages and hours for housekeeping and dietary services.

Column 3--Enter on each line, as appropriate, the **salary and wages** portion (as defined in column 2 instructions) of any reclassifications made on Worksheet A-6.

Column 4--Enter on each line the result of column 2 plus or minus column 3.

Column 5--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 4. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 15 (including subscripts), lines 26 through 43 (including subscripts), and Part III, line 7, if the hours cannot be determined, then the associated salaries must not be included in columns 2 through 4.

NOTE: The hours must reflect any change reported in column 3; For employees who work a regular work schedule, on call hours are not to be included in the total paid hours (on call hours should only relate to hours associated to a regular work schedule; overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 7 must be based on 2080 hours per year for each full time intern and resident employee. The hours reported for salaried employees who are paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week.

NOTE: *Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule; that is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3.*

Column 6--Enter on all lines (except lines 17 through 25) the average hourly wage resulting from dividing column 4 by column 5.

4005.3 Part III - Hospital Wage Index Summary.--This worksheet provides for the calculation of a hospital's average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

Columns 1 through 6--Follow the same instructions discussed in Part II, except for column 6, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01, and 8. Add to this amount lines: 28, 33, and 35.

Line 2--From Part II, enter the sum of lines 9 and 10.

Line 3--Enter the result of line 1 minus line 2.

Line 4--From Part II, enter the sum of lines 11, 12, 13, 14, and 15. (Line 16 is omitted from Part III, line 4 because physicians' teaching services are excluded from the wage index.)

Line 5--From Part II, enter the sum of lines 17, 18, and 22. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to 2 decimal places.

Line 6--Enter the sum of lines 3 through 5.

Line 7--Enter from Part II above, the sum of lines 26 through 43. If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 26 through 43 for calculating the percentage.)

4005.4 Part IV - Wage Related Costs.--The hospital must provide the contractor with a complete list of all core wage related costs included in Part II (§4005.2), lines 17 and 19 through 25. This worksheet provides for the identification of such costs.

The hospital must determine whether each wage related cost "other than core", reported on line 25, exceeds one (1) percent of the total adjusted salaries net of excludable salaries and meets all of the following criteria:

- The costs are not listed on lines 1 through 23, "Wage Related Costs Core"
- If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test.
- The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.
- The individual wage related cost is not included in salaries reported on Worksheet S-3, Part II, column 3, line 17.
- The wage related cost is not being furnished for the convenience of the employer.

For wage related costs not covered by Medicare reasonable cost principles (excluding the reporting of certain defined benefit pension costs; see instructions below), a hospital shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

Enter on each line as applicable the corresponding amount from your accounting books and/or records.

Line 3--Report pension cost for defined benefit pension plans than do not meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code.

The policy adopted in the federal fiscal year (FFY) 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) does not change the reporting basis for these costs.

NOTE: These plans generally are not funded by a funding vehicle that is for exclusive benefit of employees or their beneficiaries and do not qualify for special tax benefits, such as tax deferral of employer contributions. For such unfunded defined benefit plans, the costs of these plans are reported on a cash basis which recognizes benefit payments made during the current period. Typically these plans supplement the basic qualified defined benefit plan or provide benefits to a select class of employees, such as executives.

Line 4--Commencing with cost reporting periods used for the FFY 2013 wage index, report pension cost for defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code for the wage index. The allowable pension costs to be reported for these defined benefit pension plans shall be determined in accordance with the policy adopted in the FY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) and as discussed below. Enter the pension costs from your records or from the Wage Index Pension Cost Schedule (Exhibit 3) below. *(See CMS Pub. 15-1, chapter 21, §2142.)*

Policy

Defined Benefit Pension Plan: A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by employees. This section applies only to defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions.

Pension Contributions: Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under §401(a) of the Internal Revenue Code. For purposes of the wage index, provider pension payments shall be measured on a cash-basis without regard to *CMS Pub. 15-1, chapter 23,* §2305. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, and etcetera. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider's account is debited. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan records do not show a separate accounting of the actuarially determined cost estimates, contribution deposits, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the funding attributable to each employer.

Source of Documentation for Pension Contributions: Providers are required to obtain contribution data from the pension trustee, insurance carrier, Schedule B or SB of IRS Form 5500, and if applicable, from accounting records showing the allocation of total plan contributions to each participating provider. These records must be maintained as needed for subsequent periods.

Reasonable Compensation: In order for pension costs to be allowable, the benefits payable under the plan (attributable to employer contributions) together with all other compensation paid to the employee must be reasonable in amount.

(Continuation of Worksheet S-3, Part IV Instructions)

Line 21--Report costs of executive deferred compensation plans and awards for executives. The policy adopted in the FFY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) does not change the reporting basis for these costs. Examples of executive deferred compensation include special stock option or bonus plans and sum certain postemployment awards that are not available to other employees.

NOTE: Costs reported on line 21 excludes costs of executive deferred compensation that are defined contribution pension plans, tax-sheltered annuity plans, nonqualified defined benefit plans and qualified defined benefit plans that are available to other employees that is reportable on Lines 1 through 4, respectively.

4005.5 Part V - Contract Labor and Benefit Costs.--This section identifies the contract labor costs and benefit costs for the hospital complex and applicable subproviders and units.

Definitions:

Contract Labor Costs--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined in the instructions for Worksheet S-3, Part II, line 11. The amount of Contract Labor report on S-3, Part II, line 11 should agree with the amount reported on S-3, Part V, line 2. This is only for the hospital (not including excluded areas). The remainder of S-3, Part V should reflect Contract Labor as defined on S-3, Part II, line 11 (direct patient care for all of the excluded areas) with the aggregate total reported on line 1.

Benefit Costs--Enter the amount of employee benefit costs, also referred to as wage-related costs. Worksheet S-3, Part IV provides a list of core wage-related costs. The core wage-related costs reported on S-3, Part IV, line 24, which is spread on S-3, Part II, lines 17 and 19-25, must be reported by component on S-3, Part V. The amount reported on S-3, Part V, line 1 must agree to the allowable amount reported on S-3, Part IV, line 24. S-3, Part V, line 2 must agree to the amount reported on S-3, Part II, line 17. Each excluded area must contain their share of wage related costs so that lines 19 through 25 on S-3, Part II will agree to S-3, Part V, lines 3 through 18.

Identify the contract labor costs and benefit costs for each component on the applicable line.

4006. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a hospital-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate S-4 for each hospital-based home health agency.

Line 1--Enter the number of hours applicable to home health aide services.

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence.

Lines 3 *through* 18--Lines 3 through 18 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 3 through 18.

Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the HHA.

Compute staff FTEs for column 1 as follows*:* Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Line 19--Enter in column 1 the number of CBSAs that you serviced during this cost reporting period.

Line 20--*Enter* each *5-digit* CBSA *and/or non-CBSA (rural) code* where the reported HHA visits *were* performed. Subscript the line to accommodate the number of CBSAs you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the State of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services.

In accordance with 42 CFR 413.20 and §1895 of the Social Security Act, home health agencies transitioned from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

For	To
Hospital-based CMHC (titles V, XVIII, and XIX) shared ancillary services	Wkst. J-2, Part II, column 3, line as appropriate

TEFRA Inpatient Ratio--Transfer the TEFRA inpatient ratio on lines 50 through 94 and 96 through 98 from column 10 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) to Worksheet D-3, column 1 for each cost center.

PPS Inpatient Ratio--Transfer the PPS inpatient ratio on lines 50 through 94 and 96 through 98 from column 11 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to IPPS (see 42 CFR 412.1(a) through 412.125) to Worksheet D-3, column 1 for each cost center. The transfer of the PPS inpatient ratio also applies when the facility is an IPF subject to IPF PPS, a LTCH subject to LTCH PPS, or an IRF subject to IRF PPS (see 42 CFR 412, subparts N, O, and P, respectively).

4023.2 Part II - Calculation of Outpatient Services Cost to Charge Ratios Net of Reductions for Medicaid Only.--This worksheet is not applicable for title XVIII. It is only applicable for select state Medicaid programs. This worksheet computes the outpatient cost to charge ratios reflecting the following:

- The percentage of capital reduction as identified on Worksheet S-2, Part I, line 95, the applicable column.
- The reduction in reasonable costs of hospital outpatient services (other than the capital-related costs of such services (also known as operating reduction)) is based upon the percentage entered on Worksheet S-2, Part I, line 97, the applicable column.

Column Descriptions

Column 1--Enter the amounts for each cost center from Worksheet B, Part I, column 26, as appropriate. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89 for the hospital and if you use inpatient routine beds as observation beds. If you have a distinct observation bed area, add subscripted line 92.01 and transfer the appropriate amount from Worksheet B, Part I, column 26. Do not bring forward costs in any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the sum of the amounts for each cost center from Worksheet B, Part II, as appropriate. Do not bring forward costs in any cost center with a credit balance on Worksheet B, Part I, Worksheet B, Part II. For line 92, enter the amounts from Worksheet D-1, Part IV, column 5, line 90. Combine the hospital and subprovider amounts if applicable.

Column 3--For each line, subtract column 2 from column 1, and enter the result.

Column 4--Multiply column 2 by the appropriate capital reduction percentage, and enter the result.

Column 5--Multiply column 3 by the outpatient reasonable cost reduction percentage, and enter the result.

Column 6--Subtract columns 4 and 5 from column 1, and enter the result.

Column 7--Enter the total charges from Worksheet C, Part I, column 8.

Column 8--Divide column 6 by column 7, and enter the result.

4024. WORKSHEET D - COST APPORTIONMENT

Worksheet D consists of the following five parts:

Part I	-	Apportionment of Inpatient Routine Service Capital Costs
Part II	-	Apportionment of Inpatient Ancillary Service Capital Costs
Part III	-	Apportionment of Inpatient Routine Service Other Pass Through Costs
Part IV	-	Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
Part V	-	Apportionment of Medical and Other Health Services Costs

At the top of each part, indicate by checking the appropriate boxes the health care program, provider component, and the payment system, as applicable, for which the part is prepared.

NOTE: Only hospital components subject to PPS or TEFRA complete Worksheet D, Parts I through IV. *New children's and new cancer hospitals complete only Worksheet D, Parts III and IV (Line 85 of Worksheet S-2, Part I has a "Y" response).* CAHs do not complete Parts I through *IV*. Hospital based SNF and NF providers are added to the *Worksheet* D, Part III and will also complete a separate Worksheet D, Part IV.

Line Descriptions for Parts I Through V

Lines 30 through 43 (for Parts I and III) and lines 44 and 45 (for Part III) and 50 through 98 (for Parts II, IV, and V)--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report. Therefore, any lines subscripted on those worksheets, must subscripted on this worksheet.

4024.1 Part I - Apportionment of Inpatient Routine Service Capital Costs--This part computes the amount of capital-related costs applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part I, for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate. Complete this part for all payment methods.

Column 1--Enter on each line the capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26.

Column 2--Compute the amount of the swing bed adjustment. If you have a swing bed agreement or have elected the swing bed optional method of reimbursement, determine the amount for the cost center in which the swing beds are located by multiplying the amounts in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, Part I, line 21.

Column 3--For each line, subtract the amount, if any, in column 2 from the amount in column 1, and enter the result.

Column 4--Enter on each line the total patient days, excluding swing bed days, for that cost center. For line 30, enter the total days reported on Worksheet S-3, Part I, column 8, the sum of lines 1 and 28. For lines 31 through 43, enter the days from Worksheet S-3, Part I, column 8, lines 8 through 12, 13, and 16-18 (as applicable), respectively.

Column 5-- Divide the capital costs of each cost center in column 3 by the total patient days in column 4 for each line to determine the capital per diem cost. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the applicable cost centers. For line 30, enter the days reported on Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, line 1. For lines

31 through 43, enter the days from Worksheet S-3, Part I, columns 5, 6, or 7 as appropriate, lines 8 through 12, 13, and 16-18 (as applicable), respectively.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-1, *chapter 22,* §2217.) Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit to line 30, and decrease the appropriate intensive care or other special care unit by those days.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs applicable to inpatient routine services, as applicable.

4024.2 Part II - Apportionment of Inpatient Ancillary Service Capital Costs--This worksheet is provided to compute the amount of capital costs applicable to hospital inpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Enter on each line the capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26. For the hospital component or subprovider, if applicable, enter on line 92 the amount from Worksheet D-1, Part IV, column 1, line 90.

Column 2--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 3--Divide the capital cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost to charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 3.

Column 4--Enter on each line the appropriate title V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3, column 2. For title XVIII, enter on line 92 the observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 96 the Medicare charges for medical equipment rented by an inpatient. The charges are reimbursed under the DRG. However, you are entitled to the capital-related cost pass through applicable to this medical equipment.

NOTE: Program charges for PPS providers are reported in the cost reporting period in which the discharge is reported. TEFRA providers report charges in the cost reporting period in which they occur.

Do not include in Medicare charges any charges identified as MSP/LCC.

Column 5--Multiply the capital ratio in column 3 by the program charges in column 4 to determine the program's share of capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

4024.3 Part III - Apportionment of Inpatient Routine Service Other Pass Through Costs--This part computes the amount of pass through costs other than capital applicable to hospital inpatient routine service costs. Determine capital-related inpatient routine service costs on Worksheet D, Part I. Complete only one Worksheet D, Part III for each title. Report hospital, subprovider, hospital-based SNF and NF/ICF-MR (if applicable) information on the same worksheet, lines as appropriate. SNFs are now required to report medical education costs as a pass through cost.

Column 1--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments reported on Worksheet B-2, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no.

Column 2--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments reported on Worksheet B-2, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no.

Column 3--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, plus or minus post step down adjustments (reported on Worksheet B-2), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1 is yes and column 2 is no. Otherwise do not transfer the costs.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)(1), because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct graduate medical education costs are reimbursed as a pass through based on reasonable cost.

Column 4--Compute the amount of the swing bed adjustment. If you have a swing bed agreement, determine the amount for the cost center in which the swing beds are located by multiplying the sum of the amounts in columns 1 through 3 by the ratio of the amount entered on Worksheet D-1, Part I, line 26 to the amount entered on Worksheet D-1, Part I, line 21.

Column 5--Enter the sum of columns 1 through 3 (including subscripts) minus column 4.

Column 6--Enter on each line the total patient days, excluding swing bed days, for that cost center. Transfer these amounts from the appropriate Worksheet D, Part I, column 4. For SNFs enter total patient days from Worksheet S-3, Part I, column 8, line 19.

Column 7--Enter the per diem cost for each line by dividing the cost of each cost center in column 5 by the total patient days in column 6.

Column 8--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 6. For SNF (line 44) enter the program days from Worksheet S-3, Part I, column 6, line 19.

Column 9--Multiply the per diem cost in column 7 by the inpatient program days in column 8 to determine the program's share of pass through costs applicable to inpatient routine services, as applicable. Transfer the sum of the amounts on lines 30 through 35 and 43 to Worksheet D-1, Part I, line 50 for the hospital. If you are a title XVIII hospital paid under IPPS, also transfer this sum to Worksheet E, Part A, line 57. Transfer the amounts on lines 40 through 42 to the appropriate

Worksheet D-1, line 50 for the subprovider. Also transfer the amount on line 40 to Worksheet E-3, Part II, line 28 and the amount on line 41 to Worksheet E-3, Part III, line 29. For hospital-based SNF, NF or ICF/MR that follow Medicare principles, transfer the amount in column 9, line 44 to Worksheet E-3, Part VI, line 2 or for NF or ICF/MR to Worksheet E-3, Part VII, line 26, as applicable.

4024.4 Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs--The TEFRA rate of increase limitation applies to inpatient operating costs. In order to determine inpatient operating costs, it is necessary to exclude capital-related and medical education costs as these costs are reimbursed separately. Hospitals and subprovider components subject to IPPS *and/or OPPS* must also *exclude* direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. SNFs are required to report medical education costs as a pass through cost. Prepare a separate Worksheet D, Part IV for the SNF and NF or ICF/MR (if applicable).

This worksheet is provided to compute the amount of pass through costs other than capital applicable to hospital inpatient and outpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Transfer from Worksheet B, Part I, column 19 for each applicable line (plus or minus any adjustments reported on Worksheet *B-2*, if applicable) the nonphysician anesthetist's costs which qualify for a reasonable cost payment in accordance with 42 CFR 412.113(c). (See also §4013, line 19 description for more information.)

Column 2--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments made on Worksheet *B-2*, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 91.

Column 3--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments made on Worksheet *B-2*, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no. For the hospital component only, enter on line 92 the observation bed amount from Worksheet D-1, Part IV, column 5, line 92.

Column 4--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step down adjustments made on Worksheet *B-2*, if applicable), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1 is yes and column 2 is no, otherwise do not transfer the costs. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 93.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)(1) because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct graduate medical education costs for interns and residents in approved programs are reimbursed as a pass through based on reasonable cost.

Column 5--This column represents total inpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 through 4 and applicable subscripts.

Column 6--This column represents outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 2, 3 and 4 and applicable subscripts.

Column 7--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 8.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 9.

Column 10--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 11--Multiply the ratio in column 8 by the charges in column 10 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

For hospitals and subproviders, transfer column 11, line 200 to Worksheet D-1, Part II, column 1, line 51. If you are an IPPS hospital, also transfer this amount to Worksheet E, Part A, line 58. *If you are an IPF or IPF subprovider, also transfer this amount to Worksheet E-3, Part II, line 28. If you are an IRF or IRF subprovider, also transfer this amount to Worksheet E-3, Part III, line 29.* For SNFs for title XVIII transfer the amount on line 200 to Worksheet E-3, Part VI, line 3 or titles V and XIX, SNFs, NFs and ICF/MRs to Worksheet E-3, Part VII, line 26, as applicable.

Column 12--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 2 and applicable subscripts. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 13--Multiply the ratio in column 9 by the charges in column 12 to determine the program's share of pass through costs applicable to titles XVIII, Part B, V or XIX (if applicable) outpatient ancillary services, as appropriate.

For *providers subject to OPPS,* transfer column 13, line 200 to Worksheet E, Part B, line 9.

4024.5 Part V - Apportionment of Medical and Other Health Services Costs--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX. Title XVIII is reimbursed in accordance with 42 CFR 413.53. For services rendered on and after August 1, 2000, outpatient services are subject to outpatient PPS.

For your components subject to the prospective payment system or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 63.

NOTE: A new non-PPS hospital or subprovider (Lines 85 and/or 86 of Worksheet S-2 with a "Y" response) is cost reimbursed for all cost reporting periods through the end of its first 12 month cost reporting period. The 12 month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40 (f) is granted. If such an exemption is granted, cost reimbursement continues through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period.

Line 54--Enter the number of program discharges including deaths (excluding newborn and DOAs) for the component from Worksheet S-3, Part I, columns 12 through 14 (as appropriate), lines 14 and 16 through 18 (as appropriate). A patient discharge, including death, is a formal release of a patient.

Line 55--Enter the target amount per discharge as obtained from your contractor. The target amount establishes a limitation on allowable rates of increase for hospital inpatient operating cost. The rate of increase ceiling limits the amount by which your inpatient operating cost may increase from one cost reporting period to the next. (See 42 CFR 413.40.)

Line 56--Multiply the number of discharges on line 54 by the target amount per discharge on line 55 to determine the rate of increase ceiling.

Line 57--Subtract line 53 from line 56 to determine the difference between adjusted inpatient operating cost and the target amount.

Line 58 through 62--This line provides incentive payments when your cost per discharge for the cost reporting period subject to the ceiling is less than the applicable target amount per discharge. In addition bonus payments are provided for hospitals who have received PPS exempt payments for three or more previous cost reporting periods and whose operating costs are less than the target amount, expected costs (lesser of actual costs or the target amount for the previous year), or trended costs (lesser of actual operating costs or the target amount in 1996; or for hospitals where its third full cost reporting period was after 1996 the inpatient operating cost per discharge), updated and compounded by the market basket. It also provides for an adjustment when the cost per discharge exceeds the applicable target amount per discharge. If line 57 is zero, enter zero on lines 58 through 62. New providers skip lines 58 through 62 and go to line 63.

Line 58--If line 57 is a positive amount (actual inpatient operating cost is less than the target amount), enter on line 58 the lesser of 15 percent of line 57 or 2 percent of line 56. If line 57 is negative, do not complete line 58 (leave blank), however, complete line 62 for calculation of any adjustments to the operating costs.

Line 59--Enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 60--Enter from the prior year cost report, the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated by the market basket.

Line 61--If (line 53/line 54) is less than the lower of lines 55, 59 or 60, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 60), or 1 percent of the target amount (line 56); otherwise enter zero. (42 CFR 413.40(d)(4)(i))

Line 62--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero. (42 CFR 413.40(d)(3))

Line 63--Allowable Cost Plus incentive Payment--If line 57 is a positive amount, enter the sum of lines 52, 53, 58 and 61 (if applicable). If line 57 is a negative amount enter the sum of lines 52, 56, and 62. If line 57 is zero, enter the sum of lines 52 and 56. New providers enter the lesser of lines 53 or 56 plus line 52.

Line 64--Enter the amount of Medicare swing bed-SNF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 10 by the rate used on line 17. For CAHs multiply line 10 times the per diem calculated on line 38.

Line 65--Enter the amount of Medicare swing bed-SNF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 11 by the rate used on line 18. For CAHs multiply line 11 times the per diem calculated on line 38.

Line 66--Enter the sum of lines 64 and 65. For CAHs only transfer this amount to Worksheet E-2, column 1, line 1.

Line 67--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 12 by the rate used on line 19.

Line 68--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 13 by the rate used on line 20.

Line 69--Enter the sum of lines 67 and 68. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. If your state recognizes only one level of care obtain the amount from line 66.

4025.3 Part III - Skilled Nursing Facility, Other Nursing Facility, and Intermediate Care Facility/Mental Retardation Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX. Hospital-based SNFs complete lines 70 through 74 and 83 through 86 for data purposes only as SNFs are reimbursed under SNF PPS for title XVIII. Complete lines 70-89 for titles V and XIX. When this worksheet is completed for a component, show both the hospital and component numbers. Any reference to the nursing facility will also apply to the intermediate care facility/mental retardation unit.

Line Descriptions

Line 70--Enter the hospital-based SNF or other nursing facility routine service cost from Part I, line 37.

Line 71--Calculate the adjusted general inpatient routine service cost per diem by dividing the amount on line 70 by inpatient days, including private room days, shown on Part I, line 2.

Line 72--Calculate the routine service cost by multiplying the program inpatient days, including the private room days in Part I, line 9, by the per diem amount on line 71.

Line 73--Calculate the medically necessary private room cost applicable to the program by multiplying the days shown in Part I, line 14 by the per diem in Part I, line 35.

Line 74--Add lines 72 and 73 to determine the total reasonable program general inpatient routine service cost.

Lines 75 - 82--Apportionment of Inpatient Operating Costs for Other Nursing Facilities (NF)--These lines are used for titles V and/or XIX only. For title XVIII Medicare, skip lines 75 through 82 and continue with line 83.

Line 75--Enter the capital-related cost allocated to the general inpatient routine service cost center. For titles V and XIX, transfer this amount from Worksheet B, Part II, column 26, line 45 (NF).

Line 76--Calculate the per diem capital-related cost by dividing the amount on line 75 by the days in Part I, line 2.

Line 77--Calculate the program capital-related cost by multiplying line 76 by the days in Part I, line 9.

Line 78--Calculate the inpatient routine service cost by subtracting line 77 from line 74.

Line 79--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 80--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 79 from line 78.

Line 81--Enter the inpatient routine service cost per diem limitation. This amount is provided by your state contractor.

Line 82--Enter the inpatient routine service cost limitation. Obtain this amount by multiplying the number of inpatient days shown on Part I, line 9 by the cost per diem limitation on line 81.

Line 83--For titles V and XIX, enter the amount of reimbursable inpatient routine service cost determined by adding line 77 to the lesser of line 80 or line 82. If you are a provider not subject to the inpatient routine service cost limit, enter the sum of lines 77 and 80. For title XVIII, enter the amount from line 74.

Line 84-- Enter the program ancillary service amount from Worksheet D-3, column 3, line 200.

Line 85--Enter (only when Worksheet D-1 is used for a hospital-based SNF and NF) the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees to an SNF and/or NF. Include the amount eliminated from total costs on Worksheet A-8, line 25. If the utilization review costs are for more than one program, the sum of all the Worksheet D-1 amounts reported on this line must equal the amount adjusted on Worksheet A-8, line 25.

Line 86--Calculate the total program inpatient operating cost by adding the amounts on lines 83 through 85. Transfer this amount to the appropriate Worksheet E-3, Part VII, line 1 except for SNFs subject to SNF PPS. For NF and ICF/MR, transfer this amount to Worksheet E-3, Part VII, line 1 for titles V and XIX.

4025.4 Part IV - Computation of Observation Bed Pass Through Cost--This part provides for the computation of the total observation bed costs and the portion of costs subject to reimbursement as a pass through cost for observation beds that are only in the general acute care routine area of the hospital. For title XIX, insert the amount calculated for title XVIII for the hospital, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 87--Transfer the total observation bed days from Worksheet S-3, Part I, column 8, line 28. NOTE: Observation days are only recognized and reported in the inpatient routine area of the hospital.

Line 88--Calculate the result of general inpatient routine cost on line 27 divided by line 2.

Line 89--Multiply the number of days on line 87 by the cost per diem on line 88 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 92.

Lines 90 *through* 93--These lines compute the observation bed costs used to apportion the routine pass through costs and capital-related costs associated with observation beds for PPS, TEFRA*, and new children's and new cancer providers*. Lines 90 through 93 correspond to specific medical education programs reported on Worksheet D, Part III, columns 1, 2, and 3, respectively.

Column 1--For line 90, transfer the amount from Worksheet D, Part I, column 1, line 30 for the hospital. For line 91 through 93, enter the cost from Worksheet D, Part III, columns 1, 2 and 3, line 30.

Column 2--Enter on each line the general inpatient routine cost from line 27. Enter the same amount on each line.

Column 3--Divide column 1 by column 2 for each line, and enter the result. If there are no costs in column 1, enter 0 in column 3.

Column 4--Enter the total observation cost from line 89. Enter the same amount on each line.

Column 5--Multiply the ratio in column 3 by the amount in column 4. Use this cost to apportion routine pass through costs associated with observation beds on Worksheet D, Parts II and IV.

Transfer the amount in column 5:

From	To	To
Wkst. D-1, Part IV	Wkst. D, Part II	Wkst D, Part IV
Col. 5, line 90	Col. 1, line 92	
Col. 5, line 91		Col. 2, line 92
Col. 5, line 92		Col. 3, line 92
Col. 5, line 93		Col. 4, line 92

4028. WORKSHEET D-4 - COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS

Only certified transplant centers (CTCs) are reimbursed directly by the Medicare program for organ acquisition cost. This worksheet provides for the computation and accumulation of organ acquisition costs and charges for CTCs. Check the appropriate box (heart, liver, lung, pancreas, intestine, kidney, *or islet*) to determine which organ acquisition cost is being computed. Use a separate worksheet for each type of organ.

Hospitals that are not CTCs are not reimbursed by the Medicare program for organ acquisition costs and do not complete this worksheet. Such hospitals have to obtain revenue by the sale of any organs excised to an organ procurement organization (OPO) or CTC.

Worksheet D-4 consists of the following four parts:

- Part I - Computation of Organ Acquisition Cost (Inpatient Routine and Ancillary Services)
- Part II - Computation of Organ Acquisition Cost (Other than Inpatient Routine and Ancillary Service Costs)
- Part III - Summary of Costs and Charges
- Part IV - Statistics

4028.1 Part I - Computation of Organ Acquisition Costs (Inpatient Routine and Ancillary Services)--

Lines 1 through 7--These lines provide for the computation of inpatient routine service costs applicable to organ acquisition and for the accumulation of inpatient routine service charges for organ acquisition.

Column 1--Enter on lines 1 through 6, as appropriate, the inpatient routine charges applicable to organ acquisition. Enter on line 7 the sum of the amounts reported on lines 1 through 6.

Column 2--Enter on lines 1 through 6, as appropriate, the average per diem cost from Worksheet D-1:

Description	To Worksheet D-4, Part I, Col. 2	From Worksheet D-1, Part II
Adults & Pediatrics	line 1	col. 1, line 38
Intensive Care	line 2	col. 3, line 43
Coronary Care	line 3	col. 3, line 44
Burn Intensive Care Type Unit	line 4	col. 3, line 45
Surgical Intensive Care Type Unit	line 5	col. 3, line 46
Other Intensive Care Type Unit	line 6	col. 3, line 47

Column 3--Enter from your records on lines 1 through 6, as appropriate, total organ acquisition days (Medicare and non-Medicare). An organ acquisition day is an inpatient day of care rendered to an organ donor patient who is hospitalized for the surgical removal of an organ for transplant or a day of care rendered to a cadaver in an inpatient routine service area for the purpose of surgical removal of its organs for transplant. Enter on line 7 the sum of the days on lines 1 through 6.

Column 4--Enter on lines 1 through 6, as appropriate, the amount in column 2 multiplied by the amount in column 3. Enter on line 7 the sum of lines 1 through 6.

Lines 8 *through* 40--These lines provide for the computation of ancillary service cost applicable to organ acquisition. These lines also provide for the accumulation of inpatient and outpatient organ acquisition ancillary charges.

Column 1--Enter on lines 8 through 40 the "cost or other" cost to charges ratio from Worksheet C, column 9.

Column 2--Enter from your records inpatient and outpatient organ acquisition ancillary charges. Enter on line 41 the sum of lines 8 through 40.

Column 3--Enter on lines 8 through 40 the organ acquisition costs. Compute this amount by multiplying the ratio in column 1 by the amount in column 2 for each cost center. Enter on line 41 the sum of lines 8 through 40.

4028.2 Part II - Computation of Organ Acquisition Costs (Other Than Inpatient Routine and Ancillary Service Costs)--

Lines 42 *through* 47--Use these lines to apportion the cost of inpatient services attributable to organ acquisitions rendered in each of the inpatient routine areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the average per diem cost of interns and residents not in an approved teaching program in each of the inpatient routine areas. Obtain these amounts from Worksheet D-2, Part I, column 4, lines as indicated.

Column 2--Enter the number of organ acquisition days in each of the inpatient routine areas from Part I, column 3, lines 1 through 6, as appropriate.

Column 3--Multiply the per diem amount in column 1 by the number of days in column 2 for each cost center.

Line 48--For columns 2 and 3, enter the sum of lines 42 through 47.

Lines 49 *through* 54--These lines provide for the computation of the cost of outpatient services attributable to organ acquisitions rendered in each of the outpatient service areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the organ acquisition charges in each of the outpatient service areas. Obtain these amounts from Part I, column 2, lines 35 through 40, as appropriate.

Column 2--Enter the ratio of the outpatient costs of interns and residents not in an approved teaching program to the hospital outpatient service charges in each of the outpatient service areas. Obtain these ratios from Worksheet D-2, Part I, column 4, lines as indicated.

Column 3--Multiply the charges in column 1 by the ratios in column 2 for each cost center. Enter the sum of lines 49 through 54 on line 55.

4028.3 Part III - Summary of Costs and Charges--

Line 56--Enter in column 1 the sum of the costs in Part I, column 4, line 7 and column 3, line 41. Enter in column 3 the sum of the charges in Part I, column 1, line 7 and column 2, line 41.

Line 57--Enter in column 1 the cost of inpatient services of interns and residents not in an approved teaching program from Part II, column 3, line 48. Enter in column 3 your charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 58--Enter in column 1 the cost of outpatient services of interns and residents not in an approved teaching program from Part II, column 3, line 55. Enter in column 3 the provider charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 59--Enter in column 1 the direct organ acquisition costs and allocated general service costs from Worksheet B, Part I, column 26, lines 105, 106, 107, 108, 109, 110, or 111, whichever is applicable.

These direct costs include, but are not limited to, the cost of services purchased under arrangements or billed directly to you for:

- Fees for physician services (preadmission donor and recipient tissue typing),
- Costs for organs acquired from other providers or organ procurement organizations,
- Transportation costs of organs,
- Organ recipient registration fees,
- Surgeon's fees for excising cadaveric organs, and
- Tissue typing services furnished by independent laboratories.

NOTE: Transportation costs to ship organs outside of the United States are not an allowable cost.

If you have a schedule of charges which represents the various direct organ acquisition costs included in column 1, enter in column 3 the total of the charges which are applicable to the costs in column 1. However, if you have no such schedule of charges, enter the amount from column 1 in column 3.

Line 60--*Teaching hospitals or subproviders electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter* the cost *of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount* from Worksheet D-5, Part II, column 3, line*s* 24 *through 30, as applicable*. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, lines 24 through 30, as applicable.*

Line 61--Enter in columns 1 and 3 the sum of lines 56 through 60. This amount must be equal to or greater than the amount reported on line 66 (revenues for organs sold).

Line 62--Enter the number of total usable organs *excised and purchased minus all unusable or discarded organs* that could not be transplanted *(usable organs equals Worksheet D-4, Part IV, line 74, sum of columns 1 and 2, minus Worksheet D-4, Part IV, line 83, sum of columns 1 and 2)*. For islets since the number of islets cells injected into a recipient will vary depending on

the patient, enter the number of patients who received islets injections. Each patient is allowed a maximum of two islet injections per inpatient stay.

Line 63--Enter *the total Medicare* usable organs *that are included on line 62. Medicare usable organs include organs transplanted into Medicare beneficiaries (this excludes Medicare Advantage beneficiaries), organs sent to military hospitals (that have a reciprocal sharing agreement with the Organ Procurement Organization (OPO) in effect prior to March 3, 1988 and approved by the contractor), organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other providers and organs sent to OPOs. Do not include organs used for research*, organs sent to military hospitals (without a reciprocal sharing agreement with the OPO) in effect prior to March 3, 1988 and approved by the contractor), *organs sent* to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were totally paid by primary insurance other than Medicare, *organs that were paid by a Medicare Advantage plan, and* organs procured from a non-certified OPO.

Line 64--Enter line 63 divided by line 62.

Line 65--Enter in column 1*, the Medicare costs calculated by multiplying the ratio* in column 2, line 64 by the *total costs* in column 1, line 61. Enter in column 3*, the Medicare charges calculated by multiplying the ratio in* column 2, line 64 by the *total charges* in column 3, line 61.

Line 66--Enter in columns 1 and 3, the total revenue applicable to:

- Organs (included on line 63) furnished to other providers, *organs sent to OPOs,* and organs sent to military hospitals with a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor.

- Organs that were partially reimbursed by another primary insurer other than Medicare and were included on line 63.

  NOTE: When the primary payer makes a single payment for the transplant and acquisition, it is necessary to prorate the amount received between the transplant and the acquisition based on the charges submitted to the payer. Report the primary payer amounts applicable to organ transplants on Worksheet E, Part A, line 60. Report the primary payer amounts applicable to organ acquisition on this line.

Line 67--Enter the amount entered on line 65 minus the amount on line 66.

Line 68--Enter in all columns the total amount of organ acquisition charges billed to Medicare under Part B. This occurs when organs are transplanted into Medicare beneficiaries who, on the day of transplantation, are not entitled to Part A benefits. This computation reflects an adjustment between Medicare Part A and Part B costs and charges so that the amount added under Part B is the same amount subtracted under Part A.

Line 69--For columns 1 and 3 subtract line 68 from line 67. For columns 2 and 4 transfer that amount from line 68.

4028.4 Part IV - Statistics.--

Lines 70 *through* 84--The data entered are data applicable to living donors (column 1) and cadaveric donors (column 2). Use column 1 (living related) for kidney, partial liver, and partial lung transplants. If you complete this worksheet for hearts, pancreases, intestines, whole livers, whole lungs, or islets do not complete column 1.

Line 74--Enter the sum of lines 70 through 73.

Lines 75 *through* 82--Enter in columns 1 and 2 the appropriate number of organs sold (or transplanted). Enter in column 3 the revenue applicable to organs furnished to other providers, organ procurement organizations and others, and for organs transplanted into non-Medicare patients. Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicare patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered on these lines must also include an amount representing the acquisition cost of the organs transplanted into such patients. Determine this amount by multiplying the average cost of organ acquisition by the number of organs transplanted into non-Medicare patients not liable for payment on a charge basis.

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisitions) by the total number of organs transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 83--Enter in columns 1 and 2 the applicable number of unusable organs.

Line 84--Enter the sum of lines 75 through 83. These totals equal the totals on line 74, columns 1 and 2.

4029. WORKSHEET D-5 - APPORTIONMENT OF COST FOR *PHYSICIANS'* SERVICES *IN A* TEACHING *HOSPITAL*

A teaching hospital engaged in an approved GME residency program in accordance with 42 CFR 415.152, may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services. These services, and the supervision of interns and residents furnishing care to individual beneficiaries, are covered as hospital services for which Medicare pays the hospital on a reasonable cost basis. Teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with 42 CFR 415.160, are subject to RCEs. This worksheet provides for the computation of the RCE *limits by medical specialty and the* apportionment of reimbursable adjusted cost to titles V, XVIII, and XIX *in accordance with 42 CFR 415.162 and* CMS Pub. 15-1, *chapter 21,* §2148.

NOTE: CAHs do not complete this worksheet.

If such election is made, direct medical and surgical services to program patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the hospital staff are reimbursable as provider services on a reasonable cost basis. In addition, certain medical school costs may be reimbursed. Payments for services donated by volunteer physicians to program patients are made to a fund designated by the organized medical staff the teaching hospital or medical school.

Limits on the amount of physician compensation which may be recognized as a reasonable provider cost are imposed in accordance with 42 CFR 415.70.

Worksheet D-5 consists of *four* parts:

- Part I - Reasonable Compensation Equivalent Computation *for Cost Reporting Periods Ending Before June 30, 2014*
- Part II - Apportionment of Cost for *Physicians'* Services *in a* Teaching *Hospital for Cost Reporting Periods Ending Before June 30, 2014*
- *Part III - Reasonable Compensation Equivalent Computation for Cost Reporting Periods Ending On or After June 30, 2014*
- *Part IV - Apportionment of Cost for Physicians' Services in a Teaching Hospital for Cost Reporting Periods Ending On or After June 30, 2014*

Effective for cost reporting periods ending on or after June 30, 2014, do not complete Worksheet D-5, Parts I and II, but complete Worksheet D-5, Parts III and IV.

4029.1 Part I - Reasonable Compensation Equivalent Computation *for Cost Reporting Periods Ending Before June 30, 2014*--This part provides for the computation of the RCE limit by medical specialty of the physician on the hospital staff or physician on the medical school faculty. Complete separate parts for the hospital staff physicians and for physicians on the medical staff faculty. This part must be completed by applicable hospitals *for cost reporting periods ending before June 30, 2014*.

Where several physicians work in the same specialty, see CMS Pub. 15-1, *chapter 21,* §2182.6C for a discussion of applying the RCE limit in the aggregate for the specialty versus on an individual basis to each of the physicians in the specialty.

When RCE limits are applied on an individual basis to each physician in a medical specialty, prepare a supporting worksheet identical in columnar format to Worksheet D-5, Part I, for each medical specialty. Enter on the first line under columns 1 and 9 the line number applicable to the medical specialty (as displayed on Worksheet D-5, Part I). Enter the name of the medical specialty on the first line in columns 2 and 10. Following the first line, use a separate line to compute the adjusted cost of physician's direct medical and surgical services (column 16) for each physician.

Enter the total amount from column 16 of the supporting worksheet in column 16 of the line on Worksheet D-5, Part I, corresponding to the medical specialty for which the supporting worksheet is prepared. If the individual physician method is used, list each physician using an individual identifier that is *not the* name or social security number of the physician (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to your contractor.

NOTE: The method used on Worksheet D-5 (i.e., aggregate or individual physician) must be the same as the method used on Worksheet A-8-2.

Column Descriptions

Column 3--Enter for each medical specialty the amount of the total cost included in Worksheet A-8-2, column 3. When the individual physician method is used, enter in column 3 of the supporting worksheet the amount included on Worksheet A-8-2, column 3, for that physician.

Column 4--Enter for each medical specialty the amount of the cost included in Worksheet A-8-2, column 4, for the direct medical and surgical services, including the supervision of interns and residents by physicians on the hospital staff or by physicians on the faculty of a medical school, as appropriate.

If the individual physician method is used, enter in column 4 of the supporting worksheet the amount included on Worksheet A-8-2, column 4, for the indicated physician.

Column 5--Enter for each line of data the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation. The amount entered is the limit applicable to the physician specialty. Obtain the RCE applicable to the specialty from the table listed in the FR, Vol. 68, No. 148, page 45488, dated Friday, August 1, 2003. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 6--Enter the physician's hours allocated to professional services (i.e., professional component hours) in all components (e.g., hospitals, subproviders) of the health care complex. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, *chapter 21,* §2182.3E.)

Column 7--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 5 and the ratio of the physician's professional component hours entered in column 6 to 2080 hours.

Column 8--Enter for each line of data five percent of the amounts entered in column 7.

Column 11--You may adjust upward, up to five percent of the computed limit (column 8), the computed RCE limit in column 7 to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider or medical school.

Enter for each line of data the actual amounts of these expenses paid by the provider or medical school.

Column 12--Enter for each line of data, the result of multiplying column 4 by column 11 and dividing by column 3.

Column 13--You may also adjust upward the computed RCE limit in column 7 to reflect the actual malpractice expense incurred by the provider or by the medical school, as appropriate, for the services of a physician or group of physicians to provider patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by the provider (or medical school, if applicable).

Column 14--Enter for each line of data, the result of multiplying column 4 by column 13 and dividing by column 3.

Column 15--Enter for each line of data, the sum of columns 7 and 14 plus the lesser of columns 8 or 12.

Column 16--Enter for each line of data, the adjusted cost of direct medical and surgical services, including the supervision of interns and residents (i.e., the lesser of column 4 or column 15).

Line Descriptions

Line 11--Total the amounts in columns 3 through 8 and 11 through 16.

4029.2 Part II - Apportionment of Cost for *Physicians'* Services *in a* Teaching *Hospital for Cost Reporting Periods Ending Before June 30, 2014*--This part provides for the *accumulation and* apportionment of reimbursable cost *for* titles V, XVIII, and XIX *using the aggregate per diem method of apportionment (see CMS Pub. 15-1, chapter 22, §2218)* for the adjusted direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in CMS Pub. 15-1*, chapter 21,* §2148. Complete *a separate Part II* for the hospital and *for* each subprovider *for cost reporting periods ending before June 30, 2014*.

Line Descriptions

Line 1--Enter in the appropriate column, the adjusted cost of direct medical and surgical services, including the supervision of interns and residents, rendered to all patients by physicians on the hospital staff (column 1) and by physicians on the medical school faculty (column 2), as determined in accordance with CMS Pub. 15-1, *chapter 21,* §2148. Transfer these amounts from Part I, column 16, line 11. Enter the same amount on each component's Part II.

Line 2--Enter in column 1, the sum of the *hospital* inpatient days and the *hospital* outpatient visit days for all patients in the *hospital and each hospital subprovider*. Compute these days in the manner described in CMS Pub. 15-1, *chapter 22,* §2218.C. Enter in column 2, the same number of days as entered in column 1. Make the same entries on each *component's* Part II.

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2 for each category of physicians.

Lines 4 through 16--Enter in column 1, on the appropriate line, the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the *hospital and each hospital subprovider, as applicable*. Lines 10 through *16* contain the total of the title XVIII organ acquisition days and outpatient visit days. Enter in column 2 the same number of days as entered in column 1. Compute these days from your records in the manner described in CMS Pub. 15-1, *chapter 22,* §2218.C. *Do not complete lines 10 through 16 for an IRF, IPF or hospital subprovider(s).*

Line 17--Do not use.

Lines 18 through 31--Enter on the appropriate line the result of multiplying the days entered on lines 4 through 16 by the average cost per diem from line 3. Enter the total of columns 1 and 2 in column 3 for each line. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet.

4029.3 Part III - Reasonable Compensation Equivalent Computation for Cost Reporting Periods Ending On or After June 30, 2014--This part provides for the computation of the RCE limit of the physician on the hospital staff or physician on the medical school faculty. This part must be completed by applicable hospitals for cost reporting periods ending on or after June 30, 2014.

Column Descriptions

Columns 1 through 5, 9 through 11, and 13--For each line in columns 1 through 4, transfer the information from the corresponding columns on Worksheet A-8-2. For each line in column 5, transfer the amount from Worksheet A-8-2, column 6. For each line in columns 9 and 10, transfer the information from Worksheet A-8-2, columns 10 and 11, respectively. For each line in columns 11 and 13, transfer the amounts from Worksheet A-8-2, columns 12 and 14, respectively.

Column 6--For each line, enter the physician's hours allocated to professional services (i.e., professional component hours) in all components (e.g., hospitals, subproviders) of the health care complex. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records or other documentation supporting this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, chapter 21, §2182.3E.)

Column 7--For each line, enter the unadjusted RCE limit calculated by multiplying the RCE amount in column 5 by the ratio of the physician's professional component hours entered in column 6 to 2080 hours (column 5 x (column 6 ÷ 2080)).

Column 8--For each line, enter five percent of the amount entered in column 7.

Column 12--For each line, enter the professional component share of column 11 by multiplying column 4 by column 11 and dividing by column 3.

Column 14--Enter for each line of data the result of multiplying column 4 by column 13 and dividing by column 3.

Column 15--For each line, enter the sum of column 7 plus column 14, plus the lesser of column 8 or 12.

Column 16--For each line, enter the lesser of column 4 or column 15.

Line Descriptions

Line 200--Total the amounts in columns 3 through 8 and columns 11 through 16.

4029.4 Part IV - Apportionment of Cost for Physicians' Services in a Teaching Hospital for Cost Reporting Periods Ending On or After June 30, 2014--This part provides for the accumulation and apportionment of reimbursable cost for titles V, XVIII, and XIX using the aggregate per diem method of apportionment (see CMS Pub. 15-1, chapter 22, §2218) for the adjusted direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in CMS Pub. 15-1, chapter 21, §2148. Complete a separate Part IV for the hospital and each hospital subprovider for cost reporting periods ending on or after June 30, 2014.

Line Descriptions

Line 1--Enter the adjusted cost of direct medical and surgical services, including the supervision of interns and residents, rendered to all patients by physicians, determined in accordance with CMS Pub. 15-1, chapter 21, §2148. Transfer these amounts from Part III, column 16, line 200. When completing this worksheet for multiple components of a health care complex, enter the same amount on each component's Part IV worksheet.

Line 2--Enter the sum of the hospital inpatient days and the hospital outpatient visit days for all patients in the hospital and each hospital subprovider. Compute these days in the manner described in CMS Pub. 15-1, chapter 22, §2218.C. When completing this worksheet for the hospital or hospital subprovider(s), enter the same amount on each component's Part IV.

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2.

Lines 4 through 16--For each line, enter the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the hospital and each subprovider. Lines 10 through 16 contain the total of the title XVIII organ acquisition days and outpatient visit days. Compute these days from your records in the manner described in CMS Pub. 15-1, chapter 22, §2218.C.

Lines 18 through 30--For each line, enter the result of multiplying the days entered on lines 4 through 16 by the average cost per diem from line 3. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet. Transfer the amounts as follows:

From Worksheet D-5, Part IV	*To Worksheet*
Line 18 plus line 19	*E-3, Part VII, line 20 (title V hospital or component)*
Line 20	*E, Part A, line 56 (Medicare IPPS hospital)*
	E-3, Part I, line 3 (TEFRA hospital)
	E-3, Part II, line 15 (IPF)
	E-3, Part III, line 16 (IRF)
	E-3, Part IV, line 6 (LTCH)
	E-3, Part V, line 17 (Cost reimbursement)
Line 21	*E, Part B, line 23 (Medicare hospital Part B)*
Line 22 plus line 23	*E-3, Part VII, line 20 (title XIX hospital or component)*
Sum of lines 24 through 30	*D-4, Part III, line 60*

Line 15--Enter in the sum of lines 12 through 14 divided by three.

Line 16--Enter the number of FTE residents in the initial years of the program that meet the rolling average exception. (See 42 CFR 412.105(f)(1)(v))

Line 17--Enter the additional FTEs for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment (See 42 CFR 412.105(f)(1)(v)).

Line 18--Enter the sum of lines 15, 16 and 17.

Line 19--Enter the current year resident to bed ratio. Line 18 divided by line 4.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the *Form CMS-*2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). *If the hospital is participating in a valid emergency Medicare GME affiliation agreement under a §1135 waiver, and a portion of this cost report falls within the time frame covered by that emergency affiliation agreement, then, effective on and after October 1, 2008, enter the current year resident to bed ratio from line 19 (see FR Vol. 73, No. 161, dated August 19, 2008, page 48649, and 42 CFR 412.105(f)(1)(vi)).* Effective for cost reporting periods beginning on or after 10/1/02, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17.

Line 21--Enter the lesser of lines 19 or 20.

Line 22--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1, 1.01, 1.02, 1.03 and 3}.

IME Adjustment Calculation for the Add-on--Computation of IME payments for additional allopathic and osteopathic resident cap slots received under 42 CFR 412.105(f)(1)(iv)(C)(1)--Complete lines 23 through 28 only where the amount on line 23 is greater than zero (0).

Line 23--Section 422 IME FTE Cap--Enter the number of allopathic and osteopathic IME FTE residents cap slots the hospital received under 42 CFR 412.105(f)(1)(iv)(C)(1), section 422 of the MMA.

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10 and enter the result here. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines *25* through 28.

Line 25--Section 422 Allowable IME FTE Resident Count--If the count on line 24 is greater than zero, enter the lower of line 23 or line 24.

Line 26--Resident to Bed Ratio for Section 422--Divide line 25 by line 4.

Line 27--IME Adjustment Factor for Section 422 IME Residents--Enter the result of the following: .66 times [({1 + line 26} to the .405 power) - 1].

Line 28--IME Add On Adjustment--Enter the sum of lines 1, 1.01, 1.02, 1.03 and 3, multiplied by the factor on line 27.

Line 29--Total IME Payment--Enter the sum of lines 22 and 28.

Disproportionate Share Adjustment--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 30 through 34. Complete lines 33 and 34 only if you are an IPPS hospital and answered yes to line 22, column 1 of Worksheet S-2, Part I.

Line 30--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your contractor.)

Line 31--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus line 32, minus the sum of lines 5 and 6, plus employee discount days reported on line 30.

Line 32--Add lines 30 and 31 to equal the hospital's DSH patient percentage.

Line 33--Compare the percentage on line 32 with the criteria described in 42 CFR 412.106(c) and (d). Enter the payment adjustment factor calculated in accordance with 42 CFR 412.106(d). Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, Part I, line 22, column 2 is "Y" for yes, enter 35.00 percent on line 33.

Line 34--Multiply line 33 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 33 times line 1.01), plus ((line 33 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 33 times the sum of lines 1 and 1.03) times 25 percent.

Section 3133 of the ACA provides that for services occurring on or after October 1, 2013 a subsection (d) (i.e., IPPS hospital) hospital which is entitled to a receive a DSH payment will receive two separately calculated payments. The "empirically justified Medicare DSH payment" which represents 25 percent of the amount the hospital would have received under 42 CFR 412.106(d) is calculated on line 34. The "additional payment for uncompensated care" payment is calculated on lines 35 through 36.

Uncompensated Care Adjustment--Section 3133 of the ACA: (1) provides that for discharges occurring on or after October 1, 2013, subsection (d) hospitals' Medicare DSH payments are reduced by 75 percent (to the empirically justified Medicare DSH payment); and (2) established an uncompensated care payment amount which represents the remaining 75 percent of the DSH payments and distributes a portion of this amount to each qualifying DSH hospital based on its share of uncompensated care. Effective for cost reporting periods overlapping or beginning on or after October 1, 2013, complete lines 35 through 36, columns 1 and 2, as applicable only if you are a subsection (d) hospital and answered yes to Worksheet S-2, Part I, line 22, column 1.

If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, columns 1 and 2 are "Y", do not complete lines 35 and 35.01. If Worksheet S-2, Part I, line 22.01, either column 1 or 2 is "N", complete only the column with the "N" response for lines 35 and 35.01. A response of "Y" for both questions indicates that a hospital uncompensated care payment has been pre-determined for your hospital for the applicable FFY.

NOTE: For cost reporting periods that overlap October 1, 2013, column 1 should be left blank and only column 2 should be completed. *For cost reporting periods that begin on October 1, complete only column 2 (i.e, enter "N" for no in column 1 or leave column 1 blank).*

Line 35--If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", enter in the corresponding column the full amount (for all eligible IPPS hospitals) available for uncompensated care payments for the appropriate FFY. For example, for a cost reporting period ending December 31, 2013, enter zero in column 1 for the portion of the cost reporting period that began prior to October 1, 2013, and enter the FFY14 uncompensated care payment amount of $9,046,380,143 in column 2.

Line 35.01--If Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", enter the applicable factor 3 value determined by CMS for uncompensated care payments for the appropriate FFY in columns 1 and 2, respectively. If you are a new hospital, Worksheet S-2, Part I, line 47, column 2 is "Y", factor 3 must be calculated. In determining factor 3 the numerator is the current year cost report Medicaid days (Worksheet S-2, Part I, line 24, sum of columns 1 through 6) plus the SSI days published for the applicable FFY divided by the denominator which is a fixed amount obtained from the applicable FFY IPPS rule. For FFY14 the denominator is 36,429,747 (this represents the total IPPS hospitals Medicaid days and SSI days for FFY14). Round this factor 3 to 9 decimal places.

Line 35.02-- If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "Y", enter the hospital uncompensated care payment amount determined by CMS for the appropriate FFY in columns 1 and 2. If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", then CMS did not determine the hospital uncompensated care payment amount for that FFY. Compute this amount by multiplying line 35 times line 35.01, for columns 1 and 2, respectively. If Worksheet S-2, Part I, line 22, column 1 is "N" and/or line 34 above is zero, enter zero on this line.

Line 35.03--Enter the pro rata share of the hospital's uncompensated care payment in columns 1 and 2. Enter in column 1 (line 35.02 times the number of days in the cost reporting period prior to October 1 divided by the total days in the *FFY*). Enter in column 2 (line 35.02 times the number of days in the cost reporting period on or after October 1 divided by the total days in the *FFY*).

For example, a calendar year cost reporting period January 1, 2013 through December 31, 2013, enter zero in column 1, for the period of (January 1, 2013 through September 30, 2013) this period is prior to FFY 14; enter in column 2, for the period of (October 1, 2013 through December 31, 2013 (FFY 14)), (92 days/365 days *in FFY 14*) times line 35.02, column 2.

As another example, a calendar year cost reporting period of January 1, 2014 through December 31, 2014, enter in column 1, for the period (January 1, 2014 through September 30, 2014 (FFY 14)), (273 days/365 days in FFY 14) times lines 35.02, column 1; enter in column 2, for the period of (October 1, 2014 through December 31, 2014 (FFY 15)), (92 days/365days in FFY 15) times line 35.02, column 2.

Line 36--Enter the hospital's uncompensated care adjustment amount, (the sum of columns 1 and 2, line 35.03.)

Lines 37 through 39--Reserved for future use.

Additional Payment for High Percentage of ESRD Beneficiary Discharges--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create an additional column (column 1.01) for lines 41 and 45.

Line 40--Enter total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48447 and 48520).). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see FR 160, Vol. 76, dated August 18, 2011, page 51693) for all Medicare beneficiaries entitled to Medicare Part A. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and competitive medical plans (CMPs). These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the denominator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see FR 160, Vol. 76, dated August 18, 2011, page 51693) for all ESRD Medicare beneficiaries entitled to Medicare Part A who receive inpatient dialysis. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under *§*1876 of the Act (HMOs), and CMPs. These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

Line 41.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447). The discharges on this line are associated with Medicare covered and paid hospital stays, and are included in the discharges in Worksheet S-3, Part I, column 13, line 14. These discharges are a subset of the discharges on line 41. The discharges on this line are only used to determine the ESRD add-on payment, not eligibility for the add-on payment.

Line 42--Divide line 41, sum of columns 1 and 1.01 by line 40. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 43--Enter the total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684, and 685, as applicable. *The Medicare ESRD inpatient days must be included in the Medicare inpatient days reported in Worksheet S-3, Part I, column 6, line 14 and are part of a Medicare covered stay.*

Line 44--Enter the average length of stay expressed as a ratio to 7 days. *For cost reporting periods ending before June 30, 2014, d*ivide line 43 by line 41, sum of columns 1 and 1.01, and divide that result by 7 days. *For cost reporting periods ending on or after June 30, 2014, divide line 43 by line 41.01, sum of columns 1 and 1.01, and divide that result by 7 days.*

Line 45--Enter the average weekly cost per dialysis treatment *calculated by multiplying the unadjusted composite rate per treatment by 3. For example, the average weekly cost per dialysis treatment for CY 2013 is $435.60 ($145.20 times the average weekly number of treatments of 3).* This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates

Line 46--*For cost reporting periods ending before June 30, 2014, e*nter the ESRD payment adjustment (line 44, column 1 times line 45, column 1 times line 41, column 1 plus, if applicable, line 44, column 1 times line 45, column 1.01 times line 41, column 1.01). *For cost reporting periods ending on or after June 30, 2014, enter the ESRD payment adjustment (line 44, column 1 times line 45, column 1 times line 41.01, column 1 plus, if applicable, line 44, column 1 times line 45, column 1.01 times line 41.01, column 1.01).*

Line 47--Enter the sum of lines 1, 1.01, 1.02, 2, 2.01, 2.02, 29, 34, 36 and 46.

Line 48--Sole community hospitals are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a federal fiscal year 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a federal fiscal year 1987 base period (See 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a federal fiscal year 1996 base period (See 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a federal fiscal year 2006 base period (See 42 CFR 412.78). Medicare dependent hospitals are paid the highest of the federal payment rate, or the federal rate plus 75 percent of the amount of the excess over the federal rate of the highest rate for the 1982, 1987, or 2002 (See 42 CFR 412.79), base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your contractor. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the hospital specific rate based on the higher of the cost reporting periods beginning in FFY 1982, 1987, or 1996.

Additionally, for sole community hospitals only (effective for cost reporting periods beginning on or after January 1, 2009), use the highest of the determined hospital specific rate based on federal fiscal year 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before *April 1, 2015*, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on *March 31, 2015*.

Line 49--For SCHs, enter the greater of line 47 or 48. For MDH discharges occurring on or after October 1, 2006, and before *April 1, 2015*, if line 47 is greater than line 48, enter the amount on line 47. Where line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47.

For hospitals subscripting column 1 of line 47 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

Line 50--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 51--Enter the special exceptions payment for inpatient program capital, if applicable pursuant to 42 CFR 412.348(f) by entering the result of Worksheet L, Part III, line 13 less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 52--Enter the amount from Worksheet E-4, line 49. Complete this line only for the hospital component.

Obtain the payment amounts for lines 53 and 54 from your contractor.

Line 53--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

Line 54--Enter the special add-on payment for new technologies (see 42 CFR 412.87 and 412.88).

Line 55--Enter the net organ acquisition cost from Worksheet(s) D-4, Part III, column 1, line 69.

Line 56--*Teaching hospitals or subproviders electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter* the cost *of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount* from Worksheet D-5, Part II, column 3, line 20. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.*

Line 57--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, lines 30 through 35 for the hospital.

Line 58--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 59--Enter the sum of lines 49 through 58.

Line 60--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 60. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 60 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 60.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-4, Part III, line 66.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 60 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 61--Enter the result of line 59 minus line 60.

Line 62--Enter from the PS&R or your records the deductibles billed to program patients excluding deductibles and coinsurance associated with Model 4 BPCI payments.

Line 63--Enter from the PS&R or your records the coinsurance billed to program patients excluding deductibles and coinsurance associated with Model 4 BPCI payments.

Line 64--Enter the program allowable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 64 and 65 will be negative.

Line 65--Enter the result of line 64 (including negative amounts) times 70 percent for cost reporting periods that begin prior to October 1, 2012. For cost reporting periods that begin on or after October 1, 2012, enter the result of line 64 times 65 percent.

Line 66--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 64.

Line 67--Enter the sum of lines 61 and 65 minus the sum of lines 62 and 63.

Line 68--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in the IPPS final rule for the applicable cost reporting period. See CMS Pub. 100-04, chapter 3, §100.8.

Line 69--Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96.

For SCHs, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.

Line 70--Enter any other adjustments. Specify the adjustment in the space provided. Hardcoded subscripts of this line are identified as such.

Line 70.92--Enter the discount amount for the bundled payments for care improvement initiative (also referred to as Model 1) in accordance with ACA 2010, §3023 effective for discharges occurring on or after October 1, 2013. This demonstration actually began April 1, 2013, however the discounted payments begin October 1, 2013. Obtain this amount from the PS&R.

Line 70.93--Enter the payment adjustment amount for the hospital value-based purchasing (HVBP) program in accordance with ACA 2010, §3001 effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.94--Enter the adjustment amount resulting from the hospital readmissions reduction program in accordance with ACA 2010, §3025 effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.95--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).)

Line 70.96 through 70.98 (lines 70.96 and 70.97 are hardcoded)--Effective for discharges occurring during federal fiscal years 2011 *through* 201*5 (discharges before April 1, 2015) (e.g., standard federal fiscal years:* October 1, 2010 through September 30, 2011*;* October 1, 2011 through September 30, 2012*; etc.*), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010 *and subsequent legislation*, as addressed in 42 CFR 412.101. For cost reporting periods that are concurrent with the federal fiscal year (10/1 through 9/30), use line 70.97 only. For cost reporting periods that overlap October 1 for years 2010, 2011, 2012, 2013, *2014* and 201*5 (discharges occurring before April 1, 2015),* enter on lines 70.96 (Low *v*olume *a*djustment (enter the corresponding federal year for the period prior to 10/1)) and line 70.97 (Low *v*olume *a*djustment (enter the corresponding federal year for the period ending on or after 10/1)), and if necessary line 70.98 (low volume adjustments for additional portions of the cost reporting period, if necessary), the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with Exhibit 4 (low volume adjustment calculation schedule and corresponding instructions).

Line 71--Enter the result of line 67 plus or minus lines 69, 70.93, 70.94, 70.96, 70.97, 70.98, and line 70 and its subscripts not previously identified, minus lines 68, 70.92 and 70.95.

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 71].

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99 on line 73. Included in the interim payments are the amounts received as the estimated nursing and allied health managed care payments and capital, IME, DSH and outlier payments associated with Model 4 BPCI.

Line 74--Enter line 71 minus the sum of lines 71.01, 72 and 73. Transfer to Worksheet S, Part III.

Line 75--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 76 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 90 THROUGH 96 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original operating outlier amount from line 2 sum of all columns of this Worksheet E, Part A prior to the inclusion of lines 92, 93, 95, and 96 of Worksheet E, Part A.

Line 91--Enter the original capital outlier amount from Worksheet L, part I, line 2.

Line 92--Enter the operating outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5 - 20.1.2.7.

Line 93--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5 - 20.1.2.7.

Line 94--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §§20.1.2.5 - 20.1.2.7.)

Line 95--Enter the operating time value of money for operating related expenses.

Line 96--Enter the capital time value of money for capital related expenses.

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 96, respectively, one time for each time the cost report is reopened.

Instructions For Completing Exhibit 4--

Low Volume Adjustment Calculation Schedule:

Sections 3125 and 10314 of ACA 2010 *and subsequent legislation* amended the low-volume hospital adjustment in §1886(d)(12) of the Social Security Act by revising, for *FFY*s 2011 *through* 201*5 (discharges before April 1, 2015)* the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations *at 42* CFR 412.101 in the FFY 2011 IPPS final rule (75 FR 50238 through 50275).

The legislative amendments referenced in the preceding paragraph provide for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 *through* 201*5 (discharges before April 1, 2015)* as follows:

- Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and
- Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].

And to qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- Be more than 15 road miles from the nearest subsection (d) hospital; and
- Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data.

CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on, if applicable, for FFYs 2011 *through* 201*5 (discharges before April 1, 2015)*. However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their contractor and provide documentation that they met the mileage criteria.

The low-volume payment adjustment for eligible hospitals is based on their total per discharge payments made under §1886 of the Act, including capital IPPS payments, DSH payments, IME payments, and outlier payments. For SCHs and MDHs, the low-volume payment adjustment for eligible hospitals is based on either the federal rate or the hospital-specific payment (HSP) rate, whichever results in a greater operating IPPS payment. The low-volume payment amount calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during year end cost report settlement if any of the payment amounts upon which the low-volume payment amount is based are also recalculated at cost report settlement (for example, payments for DSH and IME or federal rate versus HSP rate payments for SCHs and MDHs).

NOTE: Because a hospital's eligibility for the low-volume payment adjustment and/or a hospital's applicable low-volume adjustment percentage can change during its cost reporting period (for example, a hospital with a cost report that spans the start of *the FFY*), it is necessary to determine the low-volume payment amount using the applicable low-volume adjustment percentage for the FFY and payment amounts listed above for a hospital's discharges that occur during the FFY for each FFY included by the hospital's cost reporting period.

After the cost report is calculated for settlement the low-volume payment adjustment must be calculated. The low-volume payment amount must be calculated by FFY. Therefore, if the cost report overlaps a FFY the information computed on Worksheet E, Part A must be recomputed by FFY accordingly. The amounts may not be prorated but must be calculated using the appropriate information. The following payment amounts are multiplied by the low-volume payment adjustment percentage by FFY:

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating Outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- ESRD Adjustment payments;
- Total Capital IPPS payment
- New Technology payments; and
- Capital Outlier Reconciliation amounts (if applicable, see instructions)

Complete Exhibit 4 to compute the low-volume adjustment payment applicable to this cost reporting period. **The following Exhibit 4 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated for settlement.**

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring in the cost reporting period either pre-entitlement (discharges occurring in the cost reporting period prior to October 1) or post-entitlement (discharges occurring in the cost reporting period on or after October 1). Discharges occurring in these periods are not eligible for the low-volume adjustment.

In addition, if there are discharges occurring during FFY 2011 *through* 201*5 (discharges before April 1, 2015)* and the provider was not eligible for the low-volume adjustment for the entire eligibility period, report the information relative to those discharges in this column, for example, where a provider has a cost reporting period ending June 30, 2011, which began prior to the October 1, 2010 effective date of the provision. Or where the low-volume adjustment for discharges occurring in this cost reporting period is effective for discharges on or after October, 1, 2010; however, the provider did not request the low-volume adjustment until November 15, 2010 and the low-volume adjustment was implemented within 30 days of the request. The period of time from October 1, 2010 until the contractor notified the provider of eligibility, which should be no later than December 15, 2010, is considered a period of ineligibility.

Column 3--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and prior to October 1st. If the cost reporting period is not concurrent with a federal year of October 1st through September 30th, do not include discharges occurring on or after October 1st in this column.

If the provider goes in and out of eligibility for discharges occurring prior to October 1st, add all discharges for the eligibility periods prior to October 1st and include in this column. If the provider's classification (i.e. SCH to small rural) changes during the eligibility period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1st.

Column 4--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and on or after October 1st. If the cost reporting period is concurrent with a federal year of October 1st through September 30th, report all discharges occurring on or after October 1st in this column. If the provider goes in and out of eligibility for discharges occurring on or after October 1st, add all discharges for the eligibility periods on or after October 1st and include in this column. If the provider's classification (i.e. SCH to small rural) changes during the eligibility period, use subscripted column 4.01 to accommodate the change for discharges occurring on or after October 1st.

Columns 3, 3.01, 4, and 4.01--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 5--Subtotal columns 2 through 4 and applicable subscripts. Column 5 must equal column 1 and any resulting rounding difference must be applied to the highest value in columns 2 through 4 and applicable subscripts.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013, in column 3.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013, in column 4.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 3 (Corresponds to Worksheet E, Part A, line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92 for each respective period. The lump sum utility produces a claim by claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the federal fiscal years spanned by the cost report separately. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the indirect medical education for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care "simulated payments" from the PS&R. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 through 4.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of line 1, *1.01, 1.02, 1.03* + line 4}. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 22.

Line 7 (Corresponds to Worksheet E, Part A, line 27)-- Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 through 4.

Line 8 (Corresponds to Worksheet E, Part A, Line 28)--IME Add On Adjustment--Enter the sum of lines 1, *1.01, 1.02, 1.03* and 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 through 4.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--*Multiply line 10 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 10 times line 1.01), plus ((line 10 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 10 times the sum of lines 1 and 1.03) times 25 percent.* The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 35.03)--Enter the uncompensated care payments.

For cost reporting periods that overlap or begin on or after October 1, 2013, when you are eligible for the low volume payment adjustment for the entire cost reporting period, enter in column 3, the uncompensated care payments from Worksheet E, Part A, column 1, line 35.03 and enter in column 4, the uncompensated care payments from Worksheet E, Part A, column 2, line 35.03.

For cost reporting periods that overlap or begin on or after October 1, 2013, when you are not eligible for the low volume payment adjustment for any portion of the cost reporting period, enter the uncompensated care payments as follows:

- *Enter in column 3, the uncompensated care payment eligible for the low volume payment adjustment for the portion of the cost reporting period prior to October 1 (calculated as the amount from Worksheet E, Part A, column 1, line 35.03 times the ratio of the number of days prior to October 1 in the cost reporting period eligible for the low volume payment adjustment divided by the total days in the cost reporting period prior to October 1).*

- *Enter in column 4, the uncompensated care payment eligible for the low volume payment adjustment for the portion of the cost reporting period on and after October 1 (calculated as the amount from Worksheet E, Part A, column 2, line 35.03 times the ratio of the number of days on and after October 1 in the cost reporting period eligible for the low volume payment adjustment divided by the total days in the cost reporting period on and after October 1).*

- *Enter in column 2, the uncompensated care payments not eligible for the low volume payment adjustment (calculated as the total uncompensated care payment, from Worksheet E, Part A, line 35.03, sum of columns 1 and 2, minus the sum of the uncompensated care payments reported in columns 3 and 4 of this exhibit). The sum of columns 2 through 4, must equal Worksheet E, Part A, line 36.*

Line 12 (Corresponds to Worksheet E, Part A, *l*ine 46)--Prorate in columns 2 through 4 the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, *l*ine 47)--Enter the sum of lines 1, *1.01, 1.02*, 2, *2.01,* 3, 9, 11, *11.01* and 12. *The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 47.*

Line 14 (Corresponds to Worksheet E, Part A, *l*ine 48)--For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments. The sum of columns 2 through 4 must equal the amount reported on Worksheet E Part A, line 48. If Worksheet E, Part A, line 47 is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, *l*ine 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, for each applicable column. If line 14, column 1 is greater than line 13, column 1, enter in columns 2 through 4, the amount reported on line 14, for each applicable column. For MDH discharges occurring on or after October 1, 2006, and before *April* 1, 20*15*, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount on line 13, for each applicable column, plus or minus 75 percent of the difference between line 14 minus line 13 for each applicable column. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 through 4, the amount from line 13, for each applicable column. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 49.

Line 16 (Corresponds to Worksheet E, Part A, *l*ine 50)--Enter in columns 2 through 4, the amounts computed from line 26, columns 2 through 4. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, *l*ine 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 18 (Corresponds to Worksheet E, Part A, *l*ine 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 through 4 accordingly. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 Subtotal--Enter in columns 2 through 4, the sum of amounts on lines 15, 16, 17 and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 through 4, the sum of the amounts on lines 15, 16 and 17.

Line 20 (Corresponds to Worksheet L, Part I, *l*ine 1)--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.01.

Line 21 (Corresponds to Worksheet L, Part I, *l*ine 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5 in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by *the sum of* lines 20 *and 20.01*. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10 in all applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by *the sum of* lines 20 *and 20.01* and enter the result. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, *20.01,* 21, *21.01,* 23 and 25. Transfer this amount to line 16. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 12.

Low-volume payment adjustment--Effective for discharges occurring during FFYs 2011 *through* 201*5 (discharges before April 1, 2015),* compute the amount of the low-volume adjustment as follows:

Line 27--Low-volume adjustment factor--Enter the appropriate adjustment factor in columns 3 and 4.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1st)--Multiply line 19 by line 27. Transfer this amount to the cost report calculated for settlement, Worksheet E, Part A, line 70.96.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1st)--Multiply line 19 by line 27. Transfer this amount to the cost report calculated for settlement, Worksheet E, Part A, line 70.97.

EXHIBIT 4

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE

LOW VOLUME CALCULATION EXHIBIT 4	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	

		W/S E, Part A line	(Amounts from WS E, Pt. A)	Pre/Post Entitlement	Prior to 10/1	On and after 10/1	(col. 2 through 4) Total	
		(0)	(1)	(2)	(3)	(4)	(5)	
1	DRG Amounts Other than Outlier Payments	1						1
1.01	*DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013*	*1.01*						*1.01*
1.02	*DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013*	*1.02*						*1.02*
1.03	*DRG for Federal specific operating payment for Model 4 BPCI*	*1.03*						*1.03*
2	Outlier payments for discharges. (see instructions)	2						2
2.01	*Outlier payment for discharges for Model 4 BPCI*	*2.02*						*2.01*
3	Operating outlier reconciliation	2.01						3
4	Managed Care Simulated Payments	3						4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21						5
6	IME payment adjustment (see instructions)	22						6
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	Amount from Worksheet E Part A, line 27 (see instructions)	27						7
8	IME Adjustment (see instructions)	28						8
9	Total IME payment (sum of lines 6 and 8)	29						9
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage (see instructions)	33						10
11	Disproportionate share adjustment (see instructions)	34						11
11.01	*Uncompensated care payments*	*36*						*11.01*
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment (see instructions)	46						12
13	Subtotal (see instructions)	47						13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48						14
15	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49						15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50						16
17	Special add-on payments for new technologies	54						17
18	Capital outlier reconciliation adjustment amount (see instructions)	93						18
19	**SUBTOTAL**							19
		W/S L, line	(Amounts from L)					
		(0)	(1)	(2)	(3)	(4)	(5)	
20	Capital DRG other than outlier	1						20
20.01	*Model 4 BPCI Capital DRG other than outlier*	*1.01*						*20.01*
21	Capital DRG outlier payments	2						21
21.01	*Model 4 BPCI Capital DRG outlier payments*	*2.01*						*21.01*
22	Indirect medical education percentage (see instructions)	5						22
23	Indirect medical education adjustment (*sum of* lines 1 *and 1.01* times line 5)	6						23
24	Allowable disproportionate share percentage (see instructions)	10						24
25	Disproportionate share adjustment (line 10 times *the sum of* lines 1 *and 1.01*)	11						25
26	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	12						26
		W/S E, Part A line	(Amounts to E pt A)					
		(0)	(1)	(2)	(3)	(4)	(5)	
27	**Low volume adjustment factor**							27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96) (prior to 10/1)							28
29	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.97) (on and after 10/1)							29

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For CAHs enter on this line 101 percent of line 11.

Line 22--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII *SNF*
Hospital	Part I, col. 9, line 9 plus line 27; or Part II, col. 7, line 37; or Part III, col. 6, line 45	Part I, col. 9, lines 10, 11 or 12; or Part II, col. 7, lines 38, 39 or 40 or Part III, col. 6, line 46, 47 or 48	Part I, col. 9, line 13; or Part II, col. 7, line 41; or Part III, col. 6, line 49

Line 23--*Teaching* hospitals or subproviders *participating in an approved GME program, electing* to be reimbursed for services *of physicians* on the basis of *reasonable* cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the *cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the* amount from Worksheet D-5, Part II, column 3, line 21. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 21.*

Line 24--Enter the sum of lines 3, 4, 8, and 9, all columns.

Computation of reimbursement Settlement

Line 25--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance, enter on this line the full coinsurance amount not the discounted amount.

Line 26--Enter the deductible and coinsurance relating to the amounts reported on line 24.

NOTE: If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, Part I, lines 155 *through* 161 columns 1 *through* 5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs, enter the deductibles on line 25 and the coinsurance on line 26.

Line 27--Subtract lines 25 and 26 from lines 21 and 24 respectively. Add to that result the sum of lines 22 and 23.

NOTE: If these services are exempt from LCC, (line 21 minus line 25 minus Worksheet D, Part V, line 202, column 7) times 80 percent, then add back Worksheet D, Part V, line 202, column 7, plus lines 22 and 23. Add to that result line 24 minus line 26.

*CAHs e*nter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 202). Add back the aforementioned 101% of lab cost and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.

Line 28--Enter in column 1 the amount from Worksheet E-4, line 50. Complete this line for the hospital component only.

Line 29--Enter in column 1 the amount from Worksheet E-4, line 36. Complete this line for the hospital component only.

Line 30--Enter in column 1 the sum of columns 1 and 1.01, lines 27 through 29.

Line 31--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, the services are treated as if they were non-program services for cost reporting purposes only. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 31. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 31 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 31.

Line 32--Enter line 30 minus line 31.

Line 33--Enter the amount of allowable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 11.

Allowable bad debts (Exclude bad debts for professional services)

Line 34--Enter from your records allowable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 33. Bad debts associated with ambulance services rendered (since these costs are reimbursed on a fee basis) are not allowable. If recoveries exceed the current year's bad debts, lines 34 and 35 will be negative.

Line 35--Multiply the amount (including negative amounts) on line 34 times 70 percent (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals.

For cost reporting periods that begin on or after October 1, 2012, multiply the amount (including negative amounts) on line 34 times 65 percent (hospitals and subproviders only).

For CAHs with cost reporting periods beginning on or after October 1, 2012, multiply the amount on line 34 (including negative amounts) times 88 percent. For cost reporting periods beginning on or after October 1, 2013, multiply the amount on line 34 times 76 percent. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.

For SNFs with cost reporting periods beginning prior to October 1, 2012, enter the amount on line 34. For cost reporting periods beginning on or after October 1, 2012, calculate this line as follows: [((line 34 - line 36) * 65 percent) + (line 36 * 88 percent)]. For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows: [((line 34 - line 36) * 65 percent) + (line 36 * 76 percent)]. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.

Line 36--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only except for the calculation of dual eligible bad debts for SNFs cost reporting periods beginning on or after October 1, 2012. This amount must also be reported on line 34.

Line 37--Enter the sum of lines 32, 33 and 34 or 35 (hospitals and subproviders only). For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 32, 33 and 35. (hospital, CAH, subproviders and SNFs).

Line 38--Enter the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 39--Enter any other adjustments. Specify the adjustment in the space provided.

Line 39.98--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices. See CMS Pub. 100-04, chapter 4, §61.3. *This is captured for informational purposes only.*

Line 39.99--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).)

Line 40--Enter the result of line 37, plus or minus line 39 and its subscripts not previously identified *(excluding line 39.98 that is for informational purposes only)*, minus lines *38 and 39.99*.

Line 40.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 40].

Line 41--Enter interim payments from Worksheet E-1, column 4, line 4. For contractor final settlements, enter the amount reported on line 5.99 on line 42. For contractor purposes it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A to Part B and report that Part B portion on line 42. Maintain the necessary documentation to support the amount of the reclassification.

Line 43--Enter line 40 minus the sum of lines 40.01, 41 and 42. Transfer this amount to Worksheet S, Part III, column 3, line as appropriate.

Line 44--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by a applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 45 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 90 THROUGH 94 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original outlier amount from line 4 (sum of all columns) prior to the inclusion of line 94 of Worksheet E, Part B.

Line 91--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 4, §10.7.2.2 - §10.7.2.4.

Line 92--Enter the rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 4, §10.7.2.2 - §10.7.2.4.)

Line 93--Enter the time value of money.

Line 94--Enter sum of lines 91 and 93.

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 93, respectively, one time for each time the cost report is reopened.

4031. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

4031.1 Part I - Analysis of Payments to Providers for Services Rendered--

Complete this worksheet for each component of the health care complex which has a separate provider or subprovider number as shown on Worksheet S-2, Part I. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. When the worksheet is completed for a component, show both the hospital provider number and the component number. Complete this worksheet only for Medicare interim payments paid by the contractor. Do not complete it for purposes of reporting interim payments for titles V or XIX or for reporting payments made under the composite rate for ESRD services. Providers paid on an interim basis on periodic interim payment (PIP) adjust the interim payments for MSP/LCC claims.

The following components use the indicated worksheet instead of Worksheet E-1:

- Hospital-based HHAs use Worksheet H-5.
- Hospital-based outpatient rehabilitation facilities use Worksheet J-4.
- RHCs/FQHCs use Worksheet M-5.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A
Columns 3 and 4 - Part B

Complete lines 1 through 4. The remainder of the worksheet is completed by your contractor. All amounts reported on this worksheet must be for services, the costs of which are included in this cost report.

NOTE: When completing the heading, enter the provider number and the component number which corresponds to the provider, subprovider, SNF, or swing bed-SNF which you indicated.

DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted.

DO NOT include fee-schedule payments for ambulance services rendered.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS, pass through payments, *and payments from the supplemental PS&R associated with the Model 4 BPCI*. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments (excluding payments made under the ESRD composite rate) payable on individual bills.

Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period.

Also, include in column 4 the total Medicare payments payable for servicing home program renal dialysis equipment when the provider elected 100 percent cost reimbursement.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer as follows:

Reimbursement Method	From Column	Transfer To
Part B Payments	4	Wkst. E, Part B, line 41
Part A Payments		
IPPS	2	Wkst. E, Part A, line 72
TEFRA	2	Wkst. E-3, Part I, line 19
IPF PPS	2	Wkst. E-3, Part II, line 32
IRF PPS	2	Wkst. E-3, Part III, line 33
LTC PPS	2	Wkst. E-3, Part IV, line 23
Cost	2	Wkst. E-3, Part V, line 31
SNF PPS Title XVIII	2	Wkst. E-3, Part VI, line 16

NOTE: For a swing bed-SNF, transfer the column 2, line 4, and column 4, line 4, amounts to Worksheet E-2, columns 1 and 2, line 20, respectively.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)

Line 5--List separately each settlement payment after the cost report is received together with the date of payment. If the cost report is reopened after the NPR has been issued, continue to report all settlement payments after the cost report is received separately on this line.

Line 6--Enter the net settlement amount (balance due the provider or balance due the program). Obtain the amounts as follows:

Worksheet E-1, Column as Indicated	From Settlement Worksheet
2	Wkst. E, Part A, line 74
4	Wkst. E, Part B, line 43
2	Wkst. E-3, Part I, line 21
2	Wkst. E-3, Part II, line 34
2	Wkst. E-3, Part III, line 35
2	Wkst. E-3, Part IV, line 25
2	Wkst. E-3, Part V, line 33
2	Wkst. E-3, Part VI, line 18

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 22. Column 4 must equal Worksheet E-2, column 2, line 22.

NOTE: On lines 3, 5, and 6, when a provider to program amount is due, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 7--Enter in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. These amounts must agree with amount due provider reported on Worksheet E, Part A, line 71 *less the amount on line 71.01*; Worksheet E, Part B, line 40 *less the amount on line 40.01*; Worksheet E-2, line 19 *less the amount on line 19.01*; Worksheet E-3, Part I, line 18 *less the amount on line 18.01*; Worksheet E-3, Part II, line 31 *less the amount on line 31.01*; Worksheet E-3, Part III, line 32 *less the amount on line 32.01*; Worksheet E-3, Part IV, line 22 *less the amount on line 22.01*; Worksheet E-3, Part V, line 30 *less the amount on line 30.01*; and Worksheet E-3, Part VI, line 15 *less the amount on line 15.01*.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4031.2 Part II - Calculation of Reimbursement Settlement for Health Information Technology-

THIS PART IS COMPLETED BY THE CONTRACTOR FOR STANDARD COST REPORTING PERIODS AND BY THE CONTRACTOR FOR NONSTANDARD COST REPORTING PERIODS.

In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, section 4102, inpatient acute care services under IPPS (providers subject to *§*1886(d) of the Act) and CAHs are eligible for health information technology (HIT) payments.

This part captures relevant data used to compute the HIT payment and records the single HIT initial payment paid by the contractor to the provider and any corresponding adjustments to this initial payment.

Data Collection Required for the Health Information Technology Calculation--

NOTE: Lines 1 through 7 must transfer data as indicated below for reporting periods which cover exactly 12 months (referred to as standard cost reporting periods and covers a range of 360 through 371 days). For cost reporting periods which cover other than exactly 12 months (less than or greater than 12 months (referred to as nonstandard cost reporting periods and covers a range of less than 360 days or greater than 371 days) lines 1 through 8 must be directly input by the contractor.

NOTE: For standard cost reporting periods, the provider will complete lines 30 and 31 in the "as filed" cost report and the amount computed on line 32 will be transferred to Worksheet S, Part III, column 4. For non-standard cost reporting periods, the "as filed" cost report will display zeros on all lines and a zero will be transferred from line 32 to Worksheet S, Part III, column 4. The contractor must complete this worksheet for nonstandard cost reporting periods.

Line 1--As defined in ARRA, §4102, transfer the total hospital discharges from Worksheet S-3, Part I, column 15, line 14.

Line 2--Transfer the Medicare days from Worksheet S-3, Part I, column 6, sum of line 1 and *lines* 8 through 12.

Line 3--Transfer the Medicare HMO days from Worksheet S-3, Part I, column 6, line 2.

Line 4--Transfer the total inpatient days from Worksheet S-3, Part I, column 8, sum of line 1 and *lines* 8 through 12.

Line 5--Transfer the hospital charges from Worksheet C, Part I, column 8, line 200.

Line 6--Transfer the hospital charity care charges from Worksheet S-10, column 3, line 20.

Line 7--CAHs only, transfer the reasonable costs to purchase certified HIT technology from Worksheet S-2, Part I, line 168.

Line 8--Calculate and enter the HIT payment in accordance with ARRA, §4102 as indicated below. This line can be overridden by the contractor in instances where the provider's circumstances require a customized HIT calculation.

For CAHs, if Worksheet S-2, lines 105 and 167 are both "Y" for yes, enter the result of {(H1)/(line 4 x H2)} + .20 times the amount on Worksheet S-2, Part I, **line 168**. (Note: the result of {(H1)/(line 4 x H2)} + .20 cannot exceed 100 percent.) The resulting amount must be fully expensed in the current reporting period. H1 = Line 2 plus line 3. H2 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200. *Round the result of H2 to 4 decimal places.*

OR

For acute care IPPS hospitals (§1886(d) of the Act), if Worksheet S-2, line 105 is "N" for no and line 167 is "Y" for yes, enter the result of {($2,000,000.00 + H1) x {(H2)/(line 4 x H3)} x H4}. If line 1 is less than 1,150 discharges then H1 equals 0 (zero). If line 1 equals 1,150 through 23,000 discharges, then H1 equals the result of line 1 minus 1,149 times $200. If line 1 is greater than or equal to 23,000 discharges then H1 = $4,370,200 [that is: 23,000 minus 1,149 times $200]. H2 = Line 2 plus line 3. H3 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200. *Round the result of H3 to 4 decimal places.* H4 = The transition factor from Worksheet S-2, Part I, line 169.

Line 9--If the EHR reporting period ending date on Worksheet S-2, line 170, column 2 is on or after April 1, 2013, enter the sequestration adjustment amount as follows: [2 percent times line 8].

Line 10--Calculate and enter the HIT payment after application of the sequestration adjustment by entering the result of line 8 minus line 9.

Lines 11 *through* 29--Reserved for future use.

Inpatient Hospital Services Under IPPS & CAH--

Line 30--Enter the initial (first) payment received for HIT assets for this cost reporting period. This initial payment is a single payment for the cost reporting period rather than a series of periodic interim payments during the period. This line must be completed by the providers for standard cost reporting periods and by the contractors for nonstandard cost reporting periods.

Line 31--Enter the sum of all additional initial payment adjustments, as applicable for this cost reporting period. Enter a positive amount on this line if the sum of the initial payment adjustments represents an increase to the initial payment. Enter a negative amount on this line if the sum of the initial payment adjustments represents a decrease to the initial payment.

Line 32--Balance Due Provider/(Program)--Calculate and enter the result of line 8 minus the sum of lines 30 and 31. Effective for cost reporting periods that overlap or begin on or after April 1, 2013, calculate and enter the result of line 10 minus the sum of lines 30 and 31. Transfer this amount to Worksheet S, Part III, column 4, line 1.

4032. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

This worksheet provides for the reimbursement calculation for swing bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing bed-SNF title XVIII, Parts A and B, and separate worksheets for swing bed-NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes.

Lines 1 *through* 9--Enter in the appropriate column on lines 1 through 7 the indicated costs for each component of the health care complex.

Line 1--Post-hospital swing beds in rural hospitals (other than CAHs) are paid in accordance with SNF PPS. Enter the total PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See 42 CFR 413.114(a)(2)) For CAHs, transfer 101 percent of the cost of swing-bed SNF inpatient routine services from Worksheet D-1, *P*art II, line 66.

Do not use lines 2 and 3, column 1 for swing bed SNF PPS providers.

Line 2--Enter the cost of swing bed-NF inpatient routine services from Worksheet D-1, Part II, line 69 (titles V and XIX only). Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services provided by swing bed-SNFs for vaccines that are cost reimbursed in column 2. CAHs transfer for title XVIII services 101 percent of the amounts from the applicable worksheets and for swing bed-SNF services that are cost reimbursed transfer 100 percent of the amount from the applicable worksheet:

Title V	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part A	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part B	from	The sum of Worksheet D, Part V, columns 6 and 7, line 202
Title XIX	from	Worksheet D-3, col. 3, line 200

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing-bed SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing bed-NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2 the total number of days in which Medicare swing bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

The following reconciliation format is recommended:

Part A Inpatient Days	Plus	Part B Only Days	Minus	Part A Coverage But No Part B Days Coverage	Equals	Medicare Part B Days

NOTE: See §4026.1.

Line 6--Enter the amount on line 4 multiplied by the number of days recorded on line 5. Also, if the hospital qualifies for the exception for graduate medical education payments in 42 CFR 413.77 (d)(1), enter the amount transferred from Worksheet D-2, Part II, column 7, line 30.

Line 7--If Worksheet E-2 is completed for a certified SNF, enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF.

Line 8--Enter the sum of lines 1 through 3, plus lines 6 and 7 for each column.

Line 9--Enter any amounts paid and/or payable by *workers'* compensation and other primary payers. (See instructions *for* Worksheet E, Part A, line 60, in §4030.1 for further clarification.)

Line 10--Line 8 minus line 9.

Line 11--Enter the deductible billed to program patients. DO NOT INCLUDE deductible applicable to physician professional services. Obtain this amount from your records.

Line 12--Enter line 10 minus line 11.

Line 13--Enter from your records the amounts billed to program patients for coinsurance. DO NOT INCLUDE coinsurance billed to program patients for physician professional services.

Line 14--In column 2, enter 80 percent of the amount on line 12.

Line 15--Enter the lesser of line 12 less line 13, or line 14.

Line 16--Enter any other adjustments.

Line 17--When Worksheet E-2 is completed for Medicare, enter the amount of bad debts (net of bad debt recoveries) for billed deductibles and coinsurance (excluding bad debts for physician professional services and bad debts arising from covered services paid under a reasonable charge-based methodology or a fee-schedule) for Part A services in column 1 and for Part B services in column 2. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--For cost reporting periods that begin prior to October 1, 2012, enter the amount on line 17. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: [((line 17 - line 18) * 65 percent) + (line 18 * 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [((line 17 - line 18) * 65 percent) + (line 18 * 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, multiply the amount on line 17 by 65 percent.

Line 18--Enter the gross allowable bad debts for dual eligible beneficiaries. For cost reporting periods that begin prior to October 1, 2012, this amount is reported for statistical purposes only. This amount must also be reported on line 17.

Line 19--For title XVIII, Part A, enter in column 1 the sum of lines 15 and 17.01 plus or minus line 16. For title XVIII, Part B, enter in column 2 the sum of lines 15 and 17.01 plus or minus line 16. For titles V and XIX, enter in column 1 the sum of line 15, plus or minus line 16.

Line 19.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 19].

Line 20--For title XVIII, enter in column 1 the amount from the appropriate Worksheet E-1, column 2, line 4, and enter in column 2 the amount from the appropriate Worksheet E-1, column 4, line 4. For contractor final settlement, report on line 21 the amount from line 5.99 for columns 2 and 4. For titles V and XIX, enter interim payments from your records.

Line 22--Enter the amount recorded on line 19 minus the sum of the amounts on lines 19.01, 20, and 21. This amount shows the balance due provider or the program. Transfer this amount to Worksheet S, Part III, columns as appropriate, lines 5 or 6 for the swing bed-SNF or the swing bed-NF, respectively.

Line 23--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

4033. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA
Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)
Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Part A Services for Title XVIII PPS SNFs
Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for cancer and children's hospitals.

Line Descriptions

Line 1--Enter the amount from Worksheet D-1, Part II, line 63.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69. If you are not an approved CTC do not complete line 2.

Line 3--*Teaching* hospitals *participating in an approved GME program, electing* to be reimbursed for services *of physicians* on the basis of reasonable cost *(see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148)*, enter the cost *of physicians. For cost reporting periods ending before June 30, 2014, transfer the* amount from Worksheet D-5, Part II, column 3, line 20. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.*

Line 4--Enter the sum of lines 1, 2 and 3.

Line 5--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year’s bad debts, lines 11 and 12 will be negative.

Line 12--Multiply the amount (including negative amounts) from line 11 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 13--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49 for the hospital component only.

Line 16--DO NOT USE THIS LINE.

Line 7--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 8--For providers that completed line 4, enter the lower of the FTE count on line 6 or the sum of the cap amounts on lines 4 and 4.01.

For providers that qualify to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D) during the new program growth period of the first new program's existence, enter the FTE count from line 7.

Beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program.

Line 9--Enter the total IPF patient days divided by the number of days in the cost reporting period (Worksheet S-3, Part I, column 8, line 1 (independent/freestanding) or 16 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 10--Enter the teaching adjustment factor by adding 1 to the ratio of line 8 to line 9. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as {(1 + (line 8 / line 9)) to the .5150 power - 1}.

Line 11--Enter the teaching adjustment by multiplying line 1 by line 10.

Line 12--Enter the adjusted net IPF PPS payments by entering the sum of lines 1, 2, 3, and 11.

Line 13--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.

Line 14--DO NOT USE THIS LINE.

Line 15--*Teaching* IPFs or IPF subproviders *participating in an approved GME program, electing* to be reimbursed for services *of physicians* on the basis of reasonable cost *(see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148)*, enter the *cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the* amount from Worksheet D-5, Part II, column 3, line 20. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.*

Line 16--Enter the sum of lines 12, 13, 14 and 15.

Line 17--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 17. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 17 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 18--Enter line 16 minus line 17.

Line 19--Enter the Part A deductibles.

Line 20--Enter line 18 minus line 19.

Line 21--Enter the Part A coinsurance.

Line 22--Enter the result of subtracting line 21 from line 20.

Line 23--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year’s bad debts, lines 23 and 24 will be negative.

Line 24--Multiply the amount (including negative amounts) from line 23 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 25--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 26--Enter the sum of lines 22 and 24.

Line 27--Enter the amount from Worksheet E-4, line 49 for the hospital component (freestanding IPF) only. Do not complete this line for an IPF unit.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 40 for the IPF subprovider. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 29--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 30.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 31--Enter the sum of lines 26 through 28 plus or minus lines 29 and 30.

Line 31.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 31].

Line 32--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 33 the amount on line 5.99.

Line 34--Enter line 31 minus the sum of lines 31.01, 32 and 33. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 35--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-1, chapter 1, §115.2.) Attach a schedule showing the details and computations.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART II. LINES 50 THROUGH 53 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original outlier amount from Worksheet E-3, Part II, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §§190.7.2.3 - 190.7.2.5.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §§190.7.2.3 - 190.7.2.5.)

Line 53--Enter the time value of money.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

4033.3 Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS--Use Worksheet E-3, Part III to calculate Medicare reimbursement settlement under IRF PPS for hospitals and subproviders. (See 42 CFR 412, subpart P.)

Use a separate copy of Worksheet E-3, Part III for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part III to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the net federal IRF PPS payment. The federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records.

In accordance with the FR, Vol. 78, No. 151, dated August 6, 2013, page 47869, effective for IRF discharges rendered on or after October 1, 2013, the IRF LIP adjustment factor is updated. Subscript column 1 for lines 1 and 3 for cost reporting periods that overlap October 1, 2013. Enter the net federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2013 in column 1 and the net federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2013 in column 1.01 to facilitate the calculation of the LIP adjustment on line 3, columns 1 and 1.01, respectively. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

Line 2--Enter the Medicare SSI ratio from your contractor as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit).

Line 3--Effective for cost reporting periods ending prior to October 1, 2013, enter the IRF LIP payment as the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through 6, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 as applicable plus employee discount days (S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

For cost reporting periods that overlap October 1, 2013, subscript column 1. To calculate the IRF LIP payment for discharges prior to October 1, 2013, enter in column 1 the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2013, enter in column 1.01 the result of {(1 + (line 2) + (L1/L2)) to the .3177 power - 1} times (line 1, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of {(1 + (line 2) +(L1/L2)) to the .3177 power - 1} times line 1.

Line 4--Enter the IRF outlier payment. Obtain this from the PS&R and/or your records.

NOTE: Complete only line 5 or line 6, but not both.

Line 5--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to Worksheet S-2, Part I, line 76, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004.

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with FR, volume 76, No. 151, dated August 5, 2011, page 47846.

Line 6--If the response to Worksheet S-2, Part I, line 76, column 2 is "Y" and your facility did not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005) enter the new cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly.

Line 7--Enter the current year unweighted FTE resident count excluding **FTEs** in the new program growth period. FTEs in the new program growth period are reported on line 8. If your fiscal year end does not correspond to the program year end and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 8--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. If your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 9--For providers that completed line 5, enter the lower of the FTE count on line 7 or the sum of the cap amounts on lines 5 and 5.01.

For providers that qualify to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005), during the new program growth period of the first new program's existence enter the FTE count from line 8.

Beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program.

Line 10--Enter the total IRF patient days divided by the number of days in the cost reporting period (Worksheet S-3, column 8, line 1 (independent/freestanding) or 17 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

NOTE: For cost reporting periods overlapping October 1, 2013, subscript column 1 (add column 1.01) for lines 11 and 12. For cost reporting periods beginning on or after October 1, 2013, do not script column 1.

Line 11--For cost reporting periods ending prior to October 1, 2013, calculate in column 1 the teaching adjustment factor by adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}.

In accordance with the FR, Vol. 78, No. 151, dated August 6, 2013, page 47869, effective for IRF discharges rendered on or after October 1, 2013, the teaching adjustment factor is updated. For cost reporting periods that overlap October 1, 2013, subscript column 1.

To calculate the teaching adjustment factor for discharges prior to October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}. To calculate the teaching adjustment factor for discharges on or after October 1, 2013, enter in column 1.01 the result of adding 1 to the ratio of

line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the 1.0163 power - 1}. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

To calculate the teaching adjustment factor for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the 1.0163 power - 1}.

Line 12--For cost reporting periods ending prior to October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11. For cost reporting periods that overlap October 1, 2013, subscript column 1. Calculate the teaching adjustment for discharges prior to October 1, 2013 in column 1 by multiplying line 1, column 1 by line 11, column 1. Calculate the teaching adjustment for discharges on or after October 1, 2013, in column 1.01 by multiplying line 1, column 1.01 by line 11, column 1.01. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. For cost reporting periods beginning on or after October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11.

Line 13--Enter the sum of line 1, columns 1 and 1.01; line 3, columns 1 and 1.01; line 4 and line 12, columns 1 and 1.01.

Line 14--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.

Line 15--DO NOT USE THIS LINE.

Line 16--*Teaching IRFs* or *IRF* subproviders *participating in an approved GME program, electing* to be reimbursed for services *of physicians* on the basis of *reasonable* cost *(see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148)*, enter the *cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the* amount from Worksheet D-5, Part II, column 3, line 20. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.*

Line 17--Enter the sum of lines 13, 14, 15 and 16.

Line 18--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 18. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

This page is reserved for future use.

4033.4 Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS--Use Worksheet E-3, Part IV to calculate Medicare reimbursement settlement under LTCH PPS for hospitals. (See 42 CFR 412, subpart O.)

Line Descriptions

Line 1--Enter the net federal LTCH PPS payment including short stay outlier payments. Obtain this information from the PS&R and/or your records.

Line 2--Enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable.

Line 5--DO NOT USE THIS LINE.

Line 6--*Teaching* hospitals *participating in an approved GME program, electing* to be reimbursed for services *of physicians* on the basis of *reasonable* cost *(see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148)*, enter the *cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the* amount from Worksheet D-5, Part II, column 3, line 20. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.*

Line 7--Enter the sum of lines 3, 4, 5 and 6.

Line 8--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 8. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

4033.5 Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement--Use Worksheet E-3, Part V, to calculate reimbursement settlement for Medicare Part A services furnished under cost reimbursement *for (1)* critical access hospital; and *(2) new children's or new cancer hospital exempt from the rate of increase limits in accordance with 42 CFR 413.40(f).*

Line Descriptions

Line 1--Enter the inpatient operating costs *for the h*ospital (CAH*, new children's hospital, or new cancer hospital) from* Worksheet D-1, Part II, line 49.

Line 2--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a CAH.

Line 3--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 1, line 69 when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter the amounts paid or payable by *workers'* compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- *Workers'* compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--CAHs enter on this line 101 percent of the amount on line 4 minus line 5. *For a new children's or new cancer hospital that is cost reimbursed, enter the result of line 4 minus line 5.*

Computation of Lesser of Reasonable Cost or Customary Charges-- *This part provides for the computation of the lesser of reasonable cost of services furnished to beneficiaries or customary charges made by you for the same services, as defined in 42 CFR 413.13(a). A new children's or new cancer hospital exempt from the rate of increase limits must complete lines 7 through 16.*

CAHs do not complete lines 7 through 16 as they are exempt from the application of the LCC principle.

Line Descriptions

Lines 7 *through* 16--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, *chapter 21,* §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, *chapter 25,* §§2570-2577.

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-3, column 2, sum of lines 50 through 98.

Line 9--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 3, line 69 when Worksheet E-3, Part V is completed for the hospital or the hospital component of a health care complex.

Line 10--Enter the sum of lines 7 through 9.

Lines 11 *through* 14--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges on line 14 over the reasonable cost on line 6.

Line 16--Enter the excess of reasonable cost on line 6 over the customary charges on line 14. Transfer line 16 to line 21.

Line 17--*Teaching* hospitals *participating in an approved GME program, electing* to be reimbursed for services *of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter* the cost *of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount* from Worksheet D-5, Part II, column 3, line 20. *For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20. CAHs do not complete this line.*

Computation of Reimbursement Settlement

Line 18--*New children's or new cancer hospitals enter the amount from Worksheet E-4, line 49. CAHs d*o not complete this line.

Line 19--Enter the sum of lines 6 and 17.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21-- *Enter the amount from line 16. If you are a nominal charge provider, enter zero.*

Line 22--Enter line 19 minus line*s* 20 and *21*.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative.

Line 26--No reduction is required for critical access hospitals for cost reporting periods beginning prior to October 1, 2012, enter the amount from line 25.

Multiply the amount from line 25 (including negative amounts) by 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 27--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25.

Line 28--Enter the sum of lines 24 and 26.

Line 29--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 29.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See *CMS* Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 30--Enter line 28, plus or minus line 29.

Line 30.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 30].

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 30.01, 31, and 32. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

4033.6 Part VI - Calculation of Reimbursement Settlement - *Title XVIII Part A PPS SNF Services*-- For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

Computation of Net Costs of Covered Services

Line Descriptions

Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 8 and 9 will be negative.

Line 9--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount must also be reported on line 8. This amount is reported for statistical purposes only for cost reporting periods beginning prior to October 1, 2012.

Line 10--DRA 2005 SNF Bad Debt--Calculate this line as follows for cost reporting periods beginning prior to October 1, 2012: [((line 8 - line 9) * 70 percent) + line 9]. This is the adjusted SNF reimbursable bad debt in accordance with DRA 2005, section 5004.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, *chapter 21,* §2104.3), and, (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, *chapter 25,* §§2570-2577.

Line 8--Enter in column 1 the program inpatient routine service charges from your records for the applicable component for *title* V *or* XIX. This includes charges for both routine and special care units.

The amounts entered on line 8 include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 9--*E*nter the sum of the appropriate program ancillary charges from Worksheet D, Part V, columns 3 and/or 4 plus subscripts as applicable, line 202 in column 2. Enter charges from Worksheet D-3, column 2, line 202 in column 1.

Line 10--Enter in column 1 for *title* V *or* XIX the organ acquisition charges from line 3.

Line 11--Enter in column 1 for *title* V *or* XIX the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 12--Enter the sum of the amounts recorded on lines 8 through 11.

Lines 13 - 16--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 15 is greater than zero, multiply line 12 by line 15, and enter the result on line 16. If you do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 13 through 15. Enter on line 16 the amount from line 12. In no instance may the customary charges on line 16 exceed the actual charges on line 12.

Line 17--Enter the excess of the customary charges over the reasonable cost. If the amount on line 16 is greater than the amount on line 4, enter the excess.

Line 18--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 4 exceeds the amount on line 16, enter the excess.

Line 19--Enter for *title* V or XIX, columns 1 and 2, the cost of services rendered by interns and residents as follows from Worksheet D-2:

	Col. 1 Title V	Col. 2 Title V	Col. 1 Title XIX	Col. 2 Title XIX
Hospital	Part I, col. 8, line 9	Part I, col. 8, line 27	Part I, col. 10, line 9	Part I, col. 10, line 27
Subprovider	Part I, col. 8, lines 10-12 as applicable		Part I, col. 10, lines 10-12 as applicable	
Nursing Facility, ICF/MR	Part I, col. 8, line 14		Part I, col. 10, line 14	

Line 20--*Teaching* hospitals or subproviders *participating in an approved GME program, electing* to be reimbursed for services *of physicians* on the basis of *reasonable* cost *(see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148)*, enter the *cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the* amounts from Worksheet D-5, Part II, column 3 *as follows:*

Title	*From Worksheet D-5, Part II, column 3*	*To Worksheet E-3, Part VII, line 20:*
V	*Line 18*	*Column 1*
V	*Line 19*	*Column 2*
XIX	*Line 22*	*Column 1*
XIX	*Line 23*	*Column 2*

For cost reporting periods ending on or after June 30, 2014, transfer the amounts from Worksheet D-5, Part IV, as follows:

Title	*From Worksheet D-5, Part IV*	*To Worksheet E-3, Part VII, line 20:*
V	*Line 18*	*Column 1*
V	*Line 19*	*Column 2*
XIX	*Line 22*	*Column 1*
XIX	*Line 23*	*Column 2*

Line 21--Enter the lesser of line 4 or line 16. If this is a CAH, or otherwise exempt from lower of cost or charges, transfer the amount from line 4.

Prospective Payment Amount

NOTE: Lines 22 through 26 must only be completed for PPS providers.

Line 22--*Enter* the total IPPS payments for titles V and/or XIX, as applicable, in column 1. Enter the total OPPS payments for *title* V *or* XIX, as applicable, in column 2. Obtain this from your books and records.

Line 23--Enter the amount of outlier payments made for IPPS discharges during the period, in column 1. Enter the outlier payment for OPPS in column 2.

Line 24--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 25--Enter in column 1 the result of Worksheet L, Part III, line 13 less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 26--Enter *in column 1,* the routine and ancillary service other pass through *costs from* Worksheet D, Part III, column 9, line 200 and from Worksheet D, Part IV, column 11, line 200, *respectively*. Enter *in column 2,* the amount from Worksheet D, Part IV, column 13, line 200.

Line 27--*For each column, e*nter the sum of lines 22 through 26.

Line 28--For *title* V *or* XIX only, enter the customary charges for IPPS in column 1 and OPPS in column 2.

Line 29--*For each column, e*nter the sum of lines 21 and 27.

Computation of Reimbursement Settlement

Line 30--*For each column, e*nter the amount, if any, from line 18.

Line 31--*For each column, e*nter the sum of lines 19 and 20 plus line 29 minus lines 5 and 6.

Line 32--*For each column, e*nter any deductible amounts imposed.

Line 33--*For each column, e*nter any coinsurance amounts imposed.

Line 34--*For each column, e*nter from your records reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries.

Line 35--Enter in column 1, the reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 36--*For each column, e*nter the sum of lines 31, 34, and 35 minus the sum of lines 32 and 33.

Line 37--*For each column, e*nter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Line 38--*For each column, e*nter the result of line 36 plus or minus line 37.

Line 39--Enter the amount from Worksheet E-4, line 31 in column 1.

Line 40--*For each column, e*nter the sum of lines 38 and 39.

Line 41--*For each column*, *enter the* interim payments *obtained* from your records.

Line 42--*For each column, e*nter the result of line 40 minus line 41. Transfer the sum of columns 1 and 2 to Worksheet S, Part III, column 1 (*t*itle V) or column 5 (*t*itle XIX), line as appropriate.

Line 43--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) AND ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.75 *through* 413.83. This worksheet applies to the direct graduate medical education cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers. Complete this worksheet if the response to line 56 of Worksheet S-2, Part I is yes. The direct medical education costs of the nursing school and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing school and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997 the unweighted direct graduate medical education FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under section 422 of Public Law 108-173.

NOTE: Do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

Also, do not complete this worksheet for residents training in the general acute care part of a CAH since the associated costs are reimbursed on a reasonable cost basis.

Complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting period. (See 42 CFR 413.77(e)(1).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount--This section computes the total approved amount.

Line Descriptions

Line 1--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your contractor. (42 CFR 413.79(c)(2)) Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.79(c)(2)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective 10/1/2001.)

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 34. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 34.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which you agree to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the total of the amounts on lines 4, 5.99, and 6. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 31 *less the amount on line 31.01*. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 31 *less the amount on line 31.01*.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4047. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 74 and 94 of Worksheet A. In other words, complete one Worksheet I series for line 74 and one for line 94, if appropriate.

4048. WORKSHEET I-1 - ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, *chapter 27,* §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 74 and 94.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 23, line 74 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 23, line 94. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 74 and 94, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 26 the amounts from Worksheet B, Part I, all columns for lines 74 and 94. The subtotal on Worksheet I-1, line 27 agrees with the sum of Worksheet B, Part I, column 26, line 74 or line 94 if a home dialysis cost center was established and used on Worksheet A.

Column 2--This column lists the statistical bases for allocating costs on Worksheet I-3.

Column 3--Enter paid hours per type of staff listed on lines 1 through 6.

Column 4--Enter full time equivalents by dividing column 3 by 2080 hours.

Line Descriptions

Lines 1 *through* 6--Enter on these lines the direct patients care salaries after adjustments and reclassification that you reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fee paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative.

Line 22--Enter the result of line 21 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--Enter the result of line 20 plus line 21. For cost reporting periods beginning on or after October 1, 2012, enter the result of line 20 plus line 22.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-1 chapter 21, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--Enter the result of line 24 plus or minus line 25.

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 26].

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines 26.01, 27 and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with CMS Pub. 15-2, chapter 1, §115.2. Attach a schedule showing the supporting details and computation.

4056. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

Line Descriptions

Line 1--Enter the total program interim payments paid to the CMHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. **(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)**

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26 *less the amount on line 26.01*.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

Line 35--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, columns as indicated, line 116.

Line 36--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 35 by the total statistic entered in the same column on line 34. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 34) must equal the total cost on line 34, Part II.

Perform the preceding procedures for each general service cost center.

4062.3 Part III - Computation of the Total Hospice Shared Costs.--This worksheet provides for the shared therapy, drugs, or medical supplies from the hospital to the hospice.

Column Description

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I column 9, lines as indicated.

Column 2--Where hospital departments provides services to the hospice, enter on the appropriate lines the charges, from the provider's records, applicable to the hospital-based hospice.

Column 3--Multiply the amount in column 2 by the ratios in column 1 and enter the result in column 3.

Line 11--Sum of column 3 lines 1 through 10.

4063. WORKSHEET K-6 - CALCUALTION HOSPICE OF PER DIEM COST

Worksheet K-6 calculates the average cost per day for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1--Transfer the total cost from Worksheet K-5, Part I, column 2*8*, line 34 less column 2*8*, line 33, plus Worksheet K-5, Part III, column 3 line 11. This line reflects the true cost including shared cost and excluding any non-hospice related activity.

Line 2--Enter the total unduplicated days from Worksheet S-9, column 6, line 5.

Line 3--Calculate the aggregate cost per day by dividing the total cost from line 1 by the total number of days from line 2.

Line 4--Enter the unduplicated Medicare days from Worksheet S-9, column 1, line 5.

Line 5--Calculate the aggregate Medicare cost by multiplying the average cost from column 4, line 3 by the number of unduplicated Medicare days on column 1, line 4 to arrive at the average Medicare cost.

Line 6--Enter the unduplicated Medicaid days from Worksheet S-9, column 2, line 5.

Line 7--Calculate the aggregate Medicaid cost by multiplying the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8--Enter the unduplicated SNF days from Worksheet S-9, column 3, line 5.

Line 9--Calculate the aggregate SNF cost by multiplying the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10--Enter the unduplicated NF days from Worksheet S-9, column 4, line 5.

Line 11--Calculate the aggregate NF cost by multiplying the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12--Enter the unduplicated Other days from Worksheet S-9, column 5, line 5.

Line 13--Enter the Aggregate cost for other days by multiplying the average cost from line 3 by the number of unduplicated Other days on line 12 to arrive at the average other cost.

Transfer this amount to Worksheet M-3, line 2.

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration costs. This is equal to the sum of the amount in column 1, line 14 plus column 2 (and applicable subscripts), line 14.

Transfer the result to Worksheet M-3, line 21.

4070. WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based RHC/FQHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

Line Descriptions

Line 1--Enter the total program interim payments paid to the RHC/FQHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Transfer the total interim payments to the title XVIII Worksheet M-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET M-5. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. **(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)**

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet M-3, line 26 *less the amount on line 26.01*.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

This page is reserved for future use.

EXHIBIT 1 - Form CMS-2552-10 Worksheets

The following is a listing of the Form CMS-2552-10 worksheets and the page number location. Changes to worksheets are indicated by redline on this and the subsequent page for this transmittal. Where only the page number changes, no redlining is indicated.

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